Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc 9920 10-19-11 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 3. Time of Death Physician/ September 3 Beverly Ann 2125 Lewis 2011 P^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 308 Jefferson St. Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. July 20 1 □ M 2 💢 F Maryland 219-60-4600 57 **Director** Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Me * al Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 ☐ No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 308 Jefferson St. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ð 1 Never Married 2 X Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Dorothy Irene Allen Edward Lester Reynolds, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Jeffery S. Lewis/Husband 308 Jefferson St., Hagerstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 9/7/2011 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 5- Munk 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cenvical cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate if any leading immediate cause. Enter Underlying Cause (Disease or linjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. anding physician and use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ f in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day this certificate has been signed by the a ral director, page 2 should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 9 Hospital: 2 🗆 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 396 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 1126 3 P 21 IW-1 21740 MO 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State SEF Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Sept Sept (800 pM Year 1 Physician/ Joseph Mauton 13 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Howard County General Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug 3, 1937 g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Missouri Director 500-38-0768 74 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Director 1 Yes 2 A No Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral 21044 United States 5400 Vantage Point Road #802 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death went of Heath and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner munor or other traumatic event, the Medical Examiner munor. 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 □ No
If Yes, Give
Year or Dates:1962-83 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Compag Computer Corp. Federal Account Manager 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Belcher Grace Joseph Mauton Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1807 California Street, NW Washington, DC 20009 Clifford Mauton/son Department of Health Important: If item 27 any injury or other tr once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Hanover, Maryland Ardent Cremation Svc. 9/15/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility H. Witzke's Family F.H., Inc. . Sign Fre of Funeral Service Ligense 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causes each line. Onset and Death Immediate Cause (Final disease or condition enca Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transi Division of Vital Records, P.O. Box 68760

SICIALI/ INTEGRICA	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23d. Date of delivery Month Day Year					
ed by Fris	9 Unknown Part II. Other significant conditions co	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
omplete		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No					
וכ	25. Was case referred to medical	26. Place of Death (Check of					
0	overniner?	Hospital: Other:	e 5 Residence 6 Other (Specify)				
care:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	3d. Describe how injury occurred				
II Certii	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)				
3	29a. Certifier 1 Certifying Physics	sician: To the best of my knowledge, death occured at the time, date and place, and	due to the cause(s) and manner as stated.				

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D64874

29d. Date signed (Month, Day, Year)

sent

edar Lane Columbia, MD 21044

hifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 7/2009

(Check

29b. Signature and

only one)

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician/ Meese 2011 3:50 Frances Rebecca 09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mid Atlantic Nursing Home 0akland Garrett 9. Birthplace (State or Foreign Country) WV 8. Date of Birth (Month, Day, Year 02 26 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 🗌 M 2 🔀 F 578-32-3579 1923 **Director** 27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State Director 1 X Yes 2 No MD Garrett 0akland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 412 N. Third St 21550 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Dora Frances (unknown) William Florence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr David Close-son 3303 Torrey Pines Circle, Riner, VA 24149 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 9/27/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 21. Signature of Juneral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home PA 21 N 2nd St, Oakland, MD 21550 ord # 1 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death ed by the a detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed to should be deta Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? his certificate has I 1 Yes 2 No Yes 26. Place of Death (Check only one) Be 25. Was case referred to medica Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 Tes ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 1 Tes 2 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deatl

To the Funeral Director;
completed filled in by the

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pragitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D15333

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas G. Johnson, M.D., 311 North Foruth St, Suite II, Oakland, MD 21550

State Registrar

31. Date filed (Month, Day, Year) SEP 16 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) T4 2011 Alvie 12:15 AM Physician/ Elwood Moore September Medical 4b. City, Town, or Location of Death 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) Examiner Lonaconing Egle Nursing & Rehab Center 8. Date of Birth (Month, Day, Yea Sept. 30 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 130 M 2 - F Maryland 78 ^{ar)}1932 Director 220-30-8205 Usual Residence of Decedent should be filed within 12 mounts, and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show it marked other than "natural", an items 25a or 28a-f show marker event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director Midland 1 X Yes 2 No Allegany 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21532 United States Funeral 14924 Railroad St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian 11. Marital Status þ 1 Never Married 2 Married white Maryland 21215-0036 1 Yes 2XXNo Specify. 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Coal College (1-4 or 5+) Elementary/Seconday (0-12) Miner unknown injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilma Hulda Alvie Edison Moore permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coc 14924 Railroad St, Midland, Maryland 21532 19a. Informant's Name/Relationship (Type, Print) Connie Appel/daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date Mt. View Cemetery 1 XBurial 2 Cremation 3 Removal from State 09/17/2011 Barton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licenses 111 Chruch St, Westernport, Maryland 21562 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Corunan Immediate Cause (Final Orsense Physician 46-20 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 as the k IF FEMALE for use a 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No ن ساد تسابعا **ساددند:** Atter this certificate has been signed by the icompleted filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 No 1 Yes 26. Place of Death (Check only one) Be (25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Medical Certificate: 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year) SEP 1 4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Jesus Tan, 4 Broadway, Frostburg, MD

07124

2011

	•	For State Registrar	State of Mar		artment of I rtificate of I			giene Reg. No.2011	31005	
Physicia Medic		1. Decedent's Name (First, Middle, La Beth Br	•	Miller			2. Date of Dea		3. Time of Death 9:25a _M	
Examin		^{4a.} Facility Name (if not institution, give Suburban Hosp		4b. City, Town, o	r Location of Death nesda		4c. County of De Montg	4c. County of Death Montgomery		
Funeral Director		130-34-1700	- 12- I	n yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	^{9. B} ^{9. 4} Ne	irthplace (State or Foreign ountry) W Jersey		
Maryland 28a-f show otified at	irector	Usual Residence of Decedent 10a. State VA 10b. County Fairf	ax	Oc. City, Town or Lo Annanda					10d. Inside City Limits 1 Yes 2 No	
n with the is 23a or nust be n	neral D	10e. Street and Number 4216 Oak Hill	Drive		10f. Zip Code 220	03		10g. Citizen of What CUSA	country?	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmoortants if time Zi is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ③ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ♠ No If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:		
21215-0036 within 72 hours after giene. er than "natural", o er tha Medical Exam, the Medical Exam	Somple	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)	ducation ade completed) College (1-4 or 5+)	(Give	O NOT use retired)	during most of work	·	16b. Kind of Busines Atlant	ic Records	
and 2 be filed wi ental Hygic ked other c event, ti	To Be (17. Father's Name (First, Middle, Last) Joseph H.Mill	er.	1142				Maiden Surname)		
Maryland d 2 should be filed salth and Mental Hy, 27 is marked oth		19a. Informant's Name/Relationship (1		19b. Mailir 42	ng Address (Street 16 Oak	and Number or Run Hill Dr	al Route Number ive Ann	; City or Town, State, 2 nandale, V	(ip Code) a. 22003	
Baltimore, oermit. Page 1 and Department of Hea Important; If item any injury or othe once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	20b. Place of Dispo cemetery, cren Beth I:	sition (Name of natory or other places srael C	em. 9/12	Date 2/2011	20c. Location - City of Woodbrid		
Balt permit Depart Import any inj		21. Signature of Funeral Service Licen	ulli					RAL CHAPE New Brun	L 08901 swick,N.J.	
Physician/ Medical	est,	Approximate Interval Between Onset and Death								
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8760 ifficate be executed gphysician and as the burial ast	ledical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Sepsis Due to (or as a co			·				
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Box 66 death cert he attendir ed for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of d Month	elivery Day Year	
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cords aw require as been s 2 should	Completed by	stage IV Deci					24a. Was a	an 24b. Were a	utopsy findings available completion of cause of	
fital Rec sician: The la certificate ha rector, page 2		25. Was case referred to medical			00 0	leas of Death (Observed)	perfor 1 Yes	med? death?	es 2 No	
Vita	To Be	examiner? 1 □ Yes 2 🎛 No	Hospital:	2 ER/Outpatien	Tout	er:		ence 6 Other (Spe		
n of ding Ph After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Ye	28b. Time of	28c. Injur work	y at		ow injury occurred	Chy	
Division of Vital Records, tal or Attending Physician: The law requires re after cleath. al Director. After this certificate has been signed in by the funeral director, page 2 should be a laborator.	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		At home, farm, streepecify)		165 2 11/10	28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,	
the Hospital thin 24 hours at the Funeral to mpleted filled	Medical	(Check 2 L Medical Exam	sician: To the best of my iner: On the basis of exam se Practioner: To the best	ination and/or invest	igation, in my opinio	on, death occurred a	t the time, date ar	nd place, and due to the	cause(s) and manner stated	
S with	_	29b. Signature and title of certifier	11.	ID	29c. License			29d. Date signed (Mon Sept. 10		
Σ		30. Name and address of person who a	completed cause of death StatUS	8600 Ol	d Georg	etown R	d Beth	esda,Md.		
Stat Registra		31. Date filed (Month, Day, Year) SEP 14 201	32. Registrar's	Signature for	W					

DHMH 17 Rev 7/2009

	For State	State of Ma	•		tment of <i>ificate of</i>					001	0.1	000
_	Registrar 1. Decedent's Name (First, Middle, L	ast)		Certi	ilicate of	Deau	,	2. Date of De	Reg. N	0./	3 Time	of Death
ian/	Marie Elizabeth Miller											
ical iner	4a. Facility Name (if not institution, gi	ve street and number)		4b. City, Town, or Location of Death						c. County of Dea		
	Meritus Medical				Hagerst				_	Vashingt		
	5. Social Security Number 6. 213–17–7922	Sex 7. Age (In yrs. last birthday)								9. Bi 1926 Mar	irthplace (State ountry)	or Foreign
	Usual Residence of Decedent							Feb. I	5, 3	L920 Mar	YIANG	
To Be Completed by Funeral Director	10a. State 10b. County		10c. City, Town	or Loca	ition					10d. Inside		
Funeral Director	Maryland Washing	gton	William	nspo								es 2 ဳ No
ral	10e. Street and Number				10f. Zip Code	•				Citizen of What C	country?	
nue	8030 Avis Mill Ro	12. Was Decedent E	ever in U.S.	13. Wa	21795 as Decedent of	Hispanic (Origin? (Sp	ecify Yes or No-	USA	14. Race - Am	erican Indian.	
by F	1 Never Married 2 Married		No	lf \	res, specify Cu	ban, Mexic	can, Puerto	Rican, etc.)		Black, Whi	te, etc.	
	3 ☐ Widowed 4X Divorced	If Yes, Give Year or Dates.		1 11	Yes 2 X I	No Spec	ity:			Specify: Wh	ite	
aldı	15. Decedent's (Specify only highest			(Give kir	nt's Usual Occ	e during m	ost of work	ing	16b.	Kind of Business	s Industry	
Completed	Elementary/Seconday (0-12)	College (1-4 or 5	1+)	nema	NOT use retire ker	a)			Н	ome		
Be	17. Father's Name (First, Middle, Las))							Maider	n Surname)		
10												
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 11527 Walnut Point Road Hagerstown, Mar											1740
	20a. Method of Disposition	(Daugnter	20b. Place of			Poin	T			Location - City o		1740
	1 X Burial 2 ☐ Cremation 3		cemeter	y, crema	tory or other p		1	Date				D
	4 Donation 5 Other (Spe		Green							illiamsp cal Home		ט
	Dalle ()sli_								liamspor		21795
	23a. Part 1. Enter the disease, or co shock, or heart failure. List only			ot enter	the mode of d	ing, such	as cardiac	or respiratory ar	rest,		Approxim	
	Immediate Cause (Final disease or condition	aCardio-R		ory	Failure	3					Onset an Minut	d Death
	resulting in death)	Due to (or as a	a consequence o									
e	Sequentially list conditions,	b. Hyperten	sion a consequence o	nft.							Years	
xamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Hyperlip	,								Years	
ш	that initiated events resulting in death) Last	V	a consequence o	f):								
Jical		d.Chronic	Renal In	isuf	ficiend	У					Years	
Physician/Medical	IF FEMALE;	220 Kura sutasma	of overseason									
cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal death		Ectopic pregna					23d. Date of d Month	elivery Day	Year
Jysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9 Unknown	t time of death	3 🗆	Other (opecity)							
by PI	Part II. Other significant conditions	contributing to death b	ut not resulting ir	n the und	derlying cause	given in Pa	art I.	23e. Did t	obacco	use contribute	to the cause o	f death?
edk								1 🗆	Yes 2	2 No 3 🗆	Probably 4	Unknowr
plet								24a. Was		24b. Were a	utopsy finding	s available
Completed								perfe	rmed?	death?		
Be	25. Was case referred to medical examiner?	Hospital:			10	Place of D	eath (Chec	k only one)				
년 일	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 Inpatie	ent 2 X ER/Our		3 🗆 DOA 28c. In	4 📙	Nursing He	ome 5 Resi		6 Other (Spe	ecify)	
cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigat	(Month, Da)		njury	W	ork? □ Yes 2	□No	Zou. Describe i	IN AA UIÌC	ary cocumed		
Certificate:	3 Suicide 6 Could no	be 28e. Place of Inju	ury - At home, far	m, stree						and Number or R	ural Route Nu	mber,
		building, etc	. (ореспу)					City or Tov	vn, Stat	e)		
Medical	(Check 2 Medical Exa	nysician: To the best of miner: On the basis of e	xamination and/or	r investig	ation, in my op	inion, death	occurred a	t the time, date	and plac	ce, and due to the	e cause(s) and	manner state
(1)	only one) 3 Certifying N	urse Practioner: To the	boot of my knowle	adna da	ath occurred at	the time d	late and pla	re and due to th	e cause	a/e) and manner a	sstated	

JW- 4

Tanvir A. Pasha, MD
31. Date filed (Month, Day, Year)
SEP 16 2011 State Registrar

d cause of death (Item 23a) (Type, Print)											
1122	Opal	Court	Hagerstown,	Maryland	21740						
32. Peg	istrar's Sign	ature	basi								

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D35497

September 15, 2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 8.per th, 9920 10-18-11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 7, Physician/ 4:59 AM M Bernice Neiman 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8100 Connecticut Avenue #915 Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year)
09/09/1922 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 102-14-6026 1 □ M 2 😾 F **Director** 88 New York 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD 1 🗆 Yes 2 😾 No Montgomery Chevy Chase 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ must be n by Funeral 8100 Connecticut Avenue #915 20815 United States or items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces Black, White, etc 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: White Specify: "natural", 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 's any injury or other traumatic event, the Meany injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Purchaser Garment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Lebowitz Lillian Isaacs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Becker - daughter 100 Falls Grove Blvd #2404 Rockville MD 20850 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
National Crematory 20c. Location - City or Town, State Date 09/13/2011 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses M01163 Barranskys Colfdberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phy ician Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 ANo

9 Unknown for Day 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Lung Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Ves 2 has page 2 this certificate upletely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗆 Yes 2 🖹 No Hospital Other: 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of Medical Certificate: 28d. Describe how injury occurred After 1 Natural injury 5 Pending Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifing Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title o certifie 29c. License number 29d. Date signed (Month, Day, Year) Po 60

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of

31. Date filed (Month, Day, Year) SEP 1 4 2011

person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Raman Tuli MD 10810 Darnestown Road, #202 Gaithersburg MD 20878

09/08/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31008 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 06:30 PM SEPTEMBER 201 MICHAEL DAVID PERRY, JR. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CECIL NORTH EAST 119 RED TOAD ROAD 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year, 1 **XX**M 2 □ F 180-62-9434 **Director** 1982 PENNSYLVANIA 29 AN Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗌 Yes 2 ី No NORTH EAST MARYLAND CECIL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 21901 119 RED TOAD ROAD Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2XXNo within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo WHITE should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", 3 Divorced 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) AUTOMOTIVE MECHANIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CINDY ANN ARMSTRONG MICHAEL DAVID PERRY, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, f Health 119 RED TOAD ROAD, NORTH EAST, MARYLAND MICHAEL D. PERRY, SR./ FATHER item Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition SEPTEMBER Department of Important: If it any injury or o GLENWOOD MEMORIAL 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 15, 2011 BROOMALL, PENNSYLVANIA 21. Signatur of Funeral Service Licente 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ schwannoma Medical resulting in death) **Examiner** Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury burial-transit Exam that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: ase a 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown cate has been sig Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and the of certifier 29d. Date signed (Month, 29c. License number

5

State Registrar SHAHNAWAZ KHAN, 2533 AUGUSTINE HERMAN HWY, SUITEA, CHESAPEAKE CITY, MD 21915
31. Date filed (Month, Day, Year)

SEP 15 2011

SEP 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

D0062190

2011

Registrar DHMH 17 Rev 7/2009

State

10

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 14 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760

P.O.

Records,

of Vital

Division

Bindu Joseph, M.D. CH 6001 Muncaster Mill Road Rockville, Maryland 20855

D60634

29d. Date signed (Month, Day, Year)

September 9, 2011

Please Type or Print in Black Indelible Ink, Fnsure All Copies Are Legible.

Amend 25 per OCME G919 9/18 F11 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.2 2. Date of Death 's Name (First, Midele, Last) 028 Day September 2011 Physician/ 20 Medical Name (if not institution, give street and number) 4b. City Jown, or Location of Death 4c. County of Death **Examiner** g. Birthplace (State or Foreign If Under 24 Hrs. Date of Birth **Funeral** tonth, Day, Min Cou Months M 2 □ F Director Usual Residence of Dece 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f shor must be notified at 10a. State Director 1 Yes 2 No 10g. Citizen of What Country 10e, Street and Number Funeral items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Flementart/Seconday (0-12) Be Middle, Maiden Surname) 17. Fainer's Name (First, Middle, Last Nother's Name (First, ٥ 19a. Informant's Name/Belationship (Type, Print) 19b. Mailing Address 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) ignate of Funeral Service Licens Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath toration Immediate Cause (Final arge Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPRO attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy Year in the past 12 months? Day 5 Other (specify) Pregnant at time of death 2 No certificate has been signed by the a rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 5 Pending M Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 3 ☐ Suicide 4 ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title 29c. License number 143238 address of person vino completed cause of death (Item 33a) (Type, Print) 21613 at. Cambridge Illiam 31. Date filed (Month, Day, Year, 32. Reg strar's Signature State 2 8 201

DHMH 17 Rev 7/2009

Registrar

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36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 🏹 Widowed	ied 2 🗆 Mai	12. Wa Arr	s Deceden ned Forces Yes 2 S es, Give	t Ever in U.S ? No			dent of His cify Cubar	spanic Or n, Mexica		cify Yes or No- Rican, etc.)	-		ck, White	American Indian, White, etc. White	
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C	Medical Examiner	er	Immediate Cause disease or condition resulting in death)	rt failure. List (Final on	a	e on each I Due to (or a	ine. 56 (2) is a consequence of the consequence o	uence of):	no c	k			or respiratory a	rrest,			Approximate Interval Between Onset and Death	
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Box	e death certif the attending thed for use a	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										elivery Day Year					
P.O.	requires that the been signed by the should be detach	by Pt	Part II. Other signi				n but not res	sulting in the	underlying	cause giv	ven in Par	t 1.					o the cause of death?	
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Records,	The law I ate has b	ompl											auto	opsy formed?		prior to death?	completion of cause of	
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Division of Vital	l or Atte after de Directo	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could deter	nined 28		Injury - At ho etc. <i>(Specif</i>)	ome, farm, sti	reet, facto	ry, office			28f. Location City or To	(Street a	and Numi te)	ber or Ri	ural Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check	Medical	Examiner: Or	the basis of	of examination	n and/or inves	stigation, in	my opinia	on, death	occurred a	nd due to the c t the time, date ce, and due to	and place	ce, and d	ue to the	cause(s) and manner stated.	
	To the within To the comp	2	29b. Signature and	title of certific						c. Licens	e number			1			th, Day, Year)	
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Amended #19b, n1s,

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Month 9 12 Day Physician/ 2011 1:53 РМ Robert Edward Rader, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 1 X M 2 🗆 F Months Days Hours Month, Day, 58 217-56-5729 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Worcester Berlin 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11003 Grays Corner Rd. Lot 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2X Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner/Operator Jewelry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မ Paul E. Rader Pauline Pratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,21811$ wife 11003 Grays Corner Rd. Lot 87, Berlin, Deborhra A. Rader 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) State Crem. 9/19/2011 Millsboro, DE 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 21811 108 MD William St., Berlin, P 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause in each line. To not enter the mode of dving, such as cardiac or respiratory arrest Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of, Examine and bunal-tran Due to (or as a consequence of): DAR 07/16/1953 attending physician Physician/Medical Adder Robert DOB 07116/14' Division of Vital Records, P.O. Box 68760 as IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Year 5 Other (specify) Pregnant at time of death cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᇫ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2X No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? iniury 5 Pending Natural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Proctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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Registrar

State

Day,

4 2011

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State of Maryland / Department of Health and Mental Hygiene 2 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 045 A M Nelson Ellsworth Stouffer Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death tuperston Jashin Date of Birth (Month, Day, Ye)

Jan. 15 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** ear If Under 24 Hrs. 1 🛛 M 2 🗆 F 85 Director 220-30-9897 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Franklin Pennsylvania Greencastle 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 17225 USA 14918 Mercersburg Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Farmer Farm is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Russell E. Stouffer Pearl V. Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17209 W. Washington Street, Hagerstown, Md. 21740 Evelyn June Sword - Sister injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 6 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Broadfording Ch. Cem. 9/18/2011 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home X 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 2 heimer disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): certificate be executed the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗐 No 2 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) e Hospital or Attending Pl 24 hours after death. e Funeral Director, After th 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury work? 1 Yes 2 No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 📈 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Marsh

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State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Leo J. Smith 13 2011 September 8:35 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lighthouse Assisted Living Ellicott City Howard Social Security Number Sex M 2 D F If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last hirthday 8. Date of Birth Birthplace (State or Foreign Country) 94 0170871917 **Director** 084-09-4921 Yrs PA Usual Residence of Decedent show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Howard Ellicott City 1 Yes 2X No 10e. Street and Number 10a, Citizen of What Country? be Funeral ral", or items 23a Examiner must b 3020 North Ridge Road W225 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. þ 1 Never Married 2 Married XYes 2 ☐ No Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ntal Hygiene. ked other than " s event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Inland Marine Adjuster Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental F marked of ပ္ William Smith Elizabeth Mooney and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Page 1 and 2 Julia Smith - wife 3020 North Ridge Road W225 Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Department of Important; If any injury or Ardent Crematory 4 Donation 5 Other (Specify) 09/19/2011 Hanover, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. same 4112 Old Columbia Pike Ellicott City, MD 21043 Thomas 23a. Part t Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Dementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Hinknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? Yes 2 K No death? 2 🗆 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Hospital: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 🗷 No ဥ Other: 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending death. 1 Tyes ☐ Accident 2 🗌 No Investigation Funeral Director; filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DAJAA September 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Andrew Lazris M.D.

SEP 1 5 2011

Registrar's Signature

6334 Cedar Lane #103 Columbia, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0 253 PM 0 MILTON ELNEST 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 538 Mc Henry Garre Messinger Lane If Under 1 Year If Under 24 H Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Days Hours Min June 21, Year 1950 Mary Tand 219-46-2047 Director 61 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 □ No Hillsborough Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 03104 975 Smyth Rd. items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Vietnam Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 14 Race - American Indian. 11. Marital Status Black, White, etc. o. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. White 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Boilermaker Local and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 687 12 Boilermaker Be and 2 should be filed Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kathleen Mosser Leo Fredlock Schenk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 975 Smyth Rd., Manchester, NH Leah H. Schenk/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Country Side Crematory Sept. 25, 2011 Davidsville, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service License P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart-faildire. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Day Month 4 Pregnant 9 Unknown Pregnant at time of death 2 No signed by the a g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performe 1 🗌 Yes 2 🔲 No Yes 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner's Hospital: 4□Nursing Home 5 Residence 6 A o Paughter's Home 2 **X**Vo 1 🗌 Yes |2 1 Inpatient 2 ER/Outpatient 3 DOA this (28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/of investigation, in my opinion, detailed at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 1726154 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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23 2011

32. Registrar's Signature

Drive OAKCAND

21558

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	_	_ For	State of Maryland	d / Depa	artment of Health ar	nd Mental Hy	giene	
_		State Registrar 1. Decedent's Name (First, Middle, L	ast)	Cei	rtificate of Death	2. Date of De	Reg. N2U	3 0 1 3. Time of Death
Physicia Medic		Thomas Dale	Symons			Septem	ber ^{Da} 20 2011	7:35 A M
Examin		4a. Facility Name (if not institution, gr 20415 Lower Geo:	rges Creek Road		4b. City, Town, or Location of I Barton		4c. County of Dea Allegan	У
Funeral Director		215–78–3735	Sex 1 X M 2 D F 7. Age (In yrs. lat	st birthday) Yrs.	If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Bir Min. June 2	9. Bi Wes	rthplace (State or Foreign T ^{nte} Virginia
Maryland 8a-f show tified at	rector	Usual Residence of Decedent 10a. State 10b. County MD Allega		, Town or Lo Bar				10d. Inside City Limits 1 ☐ Yes ※ No
with the ls 23a or 2 ust be no	Funeral Director	10e. Street and Number 20415 Lower Georg	ges Creek Road		10f. Zip Code 21521		10g. Citizen of What C United St	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>\$</u>	11. Marital Status 1 ☐ Never Married 2 🎛 Marrier 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	Black, Whi	
within 72 hou giene. er than "natu , the Medical	To Be Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)		(Give life. D	dent's Usual Occupation kind of work done during most o O NOT use retired) Manager	f working	16b. Kind of Business Food Serv	
d be filed Mental Hy arked oth		17. Father's Name (First, Middle, Las Charles Syn	t) mons			s Name (First, Middle, na Elizab		
id 2 shoul salth and f n 27 is ma		19a. Informant's Name/Relationship Tammy Symons/ w.		19ь. Маіііі 2041 5	ng Address (Street and Number of Lower Georges	or Rural Route Number Creek Road	er, City or Town, State, Z d, Barton,	ip Code) MD 21521
Page 1 annent of He ant: If iten ary or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State	ace of Dispo emetery, crer perlan	osition (Name of matory or other place) d Crematory 09	Date 9/23/2011	20c. Location - City of Cumberland	
permit. Departri Importa any inju		21. Signature of Funeral Service Lice	ensee Bal		2. Name and Address of Facility 11 Church St, V			21562
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	omplications that caused the death of one cause on each line. a. Due to (or as a consector)	hic	er the mode of dying, such as ca			Approximate Interval Between Onset and Death
be executed sician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consequence) Due to (or as a consequence)					
cate be physic s the bu		1	d					
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3	Ectopic pregnancy Other (specify)		23d. Date of d Month	elivery Day Year
ires that the signed by the detail	Ď	Part II. Other significant conditions	s contributing to death but not resu	ulting in the u	underlying cause given in Part I.		obacco use contribute t	to the cause of death?
e law requ e has beer ge 2 shou	Completed						psy prior to ormed? death?	
ian: Th rtificate ztor, pa	Be Cc	25. Was case referred to medical			26. Place of Death		2 1 No 1 Ye	es 2 No
hysici this ce al direc	은	examiner? 1 Yes 2 No	Hospital:			ing Home 5 Resi	dence 6 Other (Spe	ecify)
ding F th. After t funera	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	(Month, Day, Year)	28b. Time o injury	28c. Injury at work? M 1 □ Yes 2 □ N		how injury occurred	
tal or Attending Physician: The law rs after death. al Director: After this certificate has led in by the funeral director, page 2 a	al Certificate:	3 Suicide 6 Could no determine	t be 280 Place of Injury - At hor		eet, factory, office	28f. Location (City or To	Street and Number or R vn, State)	ural Route Number,
he Hospi iin 24 hou he Funer ipleted fill	Medical	(Check 2 Medical Exa	hysician: To the best of my knowle iminer: On the basis of examination urse Practioner: To the best of my	and/or inves	tigation, in my opinion, death occu	irred at the time, date	and place, and due to the	e cause(s) and manner stated.
To t with To t	_	29b. Signature and title of certifier	Momen	100	29c. License number	2181	29d. Date signed (Mon	-1 -001
	4	30. Name and address of person wh Dr. Gary Wagone	o completed cause of death (Item r, 928 Bishop Wa	23a) (Type, I	or., Cumberland	, MD 21502		,
Stat Registra		31. Date filed (Month, Day, Year) CFD 2.1 201	/32. Registrar's Signatu	ure fav	the state of the s			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept 12, 2011 Catherine Alberta Smith 8:45 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Frostburg Frostburg Village Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Month, Day, July 22, Maryland **Director** 217-28-9194 79 Usual Residence of Deceden show 10a. State 10b. County 10d. Inside City Limits with the Maryland at 10c. City, Town or Location Director notified 28a-f 1 Yes 2 X No MD Garrett Swanton 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral USA 1577 New Germany Road 21561 ural", or items? filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc þ 1 Never Married 2 Married Yes 2 X No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 X Widowed 4 □ Divorced white Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home 9 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic even t. Page 1 and 2 should be file trment of Health and Mental rtant: If item 27 is marked or jury or other traumatic eve ္ရ Irvin Hare Bertha Broadwater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Floyd Rounds/Nephew 21561 6988 Bittinger Rd., Swanton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or Grantsville Cemetery Sept. 18, 2011 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. Signature of Funeral Service Licenses P.O. Box 275, Grantsville, MD Oliva 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Pftynicino/ CELESRO VASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami and that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death ed by the a detached f g Unknown 24 hours after death.
25 hours after death.

Funeral Director: After this certificate has been signed by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ္ဝ 1 ☐ Yes 2 ₩ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Natural Accider 5 Pending injury Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier within 24 ho To the Fund completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

Registrar

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 1 6 201

Harjit Sidhu, 925 Bishop Walsh Rd., Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SWAUGER LAVONNE Medical 4a. Facility Name (if not institution, give street and number)
WMHS REGIONAL MEDICAL CTR. **Examiner** 4c. County of Death UMBERLAND ALLEGAN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F (Month, Day, Year) Months Days Country) Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at by Funeral Director 10d. Inside City Limits MO ALLEGANY CUMBERLAND 1 Yes 2 No 10e. Street and Number items 23a or ner must be n 10g. Citizen of What Country? 512 Winifred USA "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Yes 2 No Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ☒ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) traumatic event, the 10 OWN tomemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PLESSINGER WATSON OLIVER -LORA BELLE (Un Known 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and .
Department of Health
Important if item 27 any injury or other tra 1 and 2 s of Health a item 27 i Fossilville RD., Buffalo Mills, PA John A. SWAUGER SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 \boxtimes Burial 2 \square Cremation 3 \boxtimes Removal from State 9-9-11 MODL Buffalo Mills 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HARVEY H. Zeigler Funeral 169 CLARENCE ST'HYNOMAN PA1554S 23a. Part 1 Enter the diseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. I st only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) WOO Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months? Month Day Year 1 Yes 2 No g 🗌 Unknown the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performed Yes 2 1 🔲 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, t of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 \square Yes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 14 Natural work?
1 Yes 2 No 5 Pending injury Division 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certi 00033280 30. Name and address of person vilo completed cause of death (Item 23a) (Type, Print) 625 Kent Ave Suite 101 Cumberland MD GUPTA MO 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2000

State

backe

32 Registrar's Signature

SEP 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 3 | 020 11-06776 Jonathon Michael Soult Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Medical Examiner Michael 0403 hrs Jonathon September 8, 2011 Soult 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Railroad crossing at Shellsburg Road **Filerslie** Allegany 5. Social Security Number If Under 1 Year If Under 24Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Maryland Country) Director Months Days Hours 212-21-0734 1 XM 2 F 23 06/22/1988 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Allegany Ellerslie or 28a-f show 1 Yes 2 X No n 27 is marked other than "natural", or items 23a or 28a-f show numatic event, the Medical Examiner must be notified at once. IMOOF, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a, or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14211 Temple Street 21529 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes 3 Widowed If Yes, Give Year 4 Divorced 1 Yes 2 X No specify: Specify: <u>۾</u> White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cook Restaurant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Soult Wayne Allen Kellie Lynn Hardman Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl L. Hardman / Grandfather P.O. Box 322, Ellerslie, MD 21529 20a. Method of Disposition or other tra 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Department of Restlawn Mem. Gardens 09/12/201 LaVale, Maryland 4 Donation 5 Other Specify: Adams Family Funeral Home, P.A. Signature of Funeral Service Licensee 22. Name and Address of Facility 404 Decatur Street, Cumberland, MD 21502 Physician Medical 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and a. Multiple Blunt Force Injuries Death Immediate Cause (Final disease **≟xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical AMENDED 27, per me, g920 10-25-11 sm UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Day Year 2 past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown હ n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available r this certificate has b prior to completion of cause of death? autopsy performed? 1 🗸 Yes Yes 2 No 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene ۵ 1 Yes After t 28a. Date of Injury (Month, Day,Year) Sep 8, 2011 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject struck by train 1 Natural 0356 hrs Director: d in by the f 1 Yes 2 ✔ No Pending 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Railroad Crossing at Shellsburg Road, Ellerslie, MD (Specify) Railroad tracks 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME September 8, 2011 30. Name and address of person who completed cause of death (Item 23a)

OCME 2006

31. Date filed (Month Day Year) 2011 Registra DHMH 17 Rev 1/2001

State

Russell Alexander MD.

900 W. Baltimore Street, Baltimore, MD 21223

Assistant Medical Examiner

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sep 8, 2011 Physician/ 7:58 AM Frances Shaner Martha Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Cumberland Allegany 819 Brookfield Avenue Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Jun 20 1 □ M 2 □**X** ^{ar}1926 Director 220-16-6014 85 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Cumberland MD Allegany 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21502 819 Brookfield Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: Maryland 21215-0036 white 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) iled within 72 h I Hygiene. other than "ni College (1-4 or 5+) **5+** Elementary/Seconday (0-12) School Teacher should be filed with and Mental Hygien ris marked other th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wanda Flora ည Alex T. Shaner permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) Karen Miller caregive 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Sunset Memorial Park 9/9/2011 MD Cumberland Donation 5 Oher (Specify) of Funeral Se 22. Name ant Address II Full Fral Home, PA Signatu 108 Virginia Avenue: Cumberland, MD 21502 Part 1 Enter the disease, or complications to shock, or heart failure. List only one cause of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ buller disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence or). ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be to thours after death.
 Funeral Director; After this certificate has been signed by the attending physicia. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 2 No 9 Unknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) completed filled in by the funeral director, Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1-1 Natural 5 Pending 1 🗌 Yes 2 🗎 No Accident Investigation Suicide
Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 025 Kent Ave. Ste. 101 Cumberland, MD 21502 GIUPTA M.D 1 2 2011 Registrar's Signat State Registrar

29b. Signature and title of ce

29c. License number

DO0 33280

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death vignth Physician/ William H. Twigg Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western Maryland Regional Medical Center Cumberland Social Security Numbe If Under 24 Hrs 8. Date of Birth (Month Day, Year) July 28, 1933 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Months Hours 1 🗶 M 2 🗌 Maryland 78 **Director** 220-32-4858 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director **Eckhart Mines** 1X Yes 2 ☐ No Allegany Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10621 Laurel Hill Drive SW Funeral U.S.A. 21528-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖔 No Specify. Specify: "natural", If Yes, Give Year or Dates KOREA White Completed 3 ☑ Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Fiber Spinning Textile Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Twigg Sr. Mary Margaret Strachan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 21528-Maryland 10621 Laurel Hill Drive SW **Eckhart Mines** Jeremy Twigg son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗶 Burial 2 🗌 Cremation 3 🗆 Removal from State September 17, 2011 Maryland LaVale Hillcrest Memorial Park injury 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Malignan disease or condition resulting in death) Medical Due to (or as a nsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Physician/Medical Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the bunal-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No certificate Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes 2 🗹 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: A completed filled in by the fi Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year, 29b. Signature and title of certif 3+

State Registrar umberland

21503

rson who completed cause of death (Item 23a) (Type, Print)

P 1 5 2011

SEP

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

SEP 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary L. Wagoner, M.D., 925 Bishop Walsh Dr., Cumberland, MD

32. Registrar's Signature

29c. License number

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2011

			For State		State of IV	laryland		artment of <i>tificate of</i>		and iv		giene Reg. No			0 1	
	- · · ·		Registrar 1. Decedent's Name	(First, Middle, Las	t)		007	tirrouto or	Boutin		2. Date of De	ath	201	-	3. Time of	0.24
	Physicia Medio	al		M. Vesp							Septem		14 20	5 11	11:0	7 p ^M
	Examin	er	4a. Facility Name (if r	not institution, give Oxberry (4b. City, Town,	or Location dstoc		4c. County of Death Howard					
U.	Funeral		5. Social Security Nu			ge (In yrs. la	st birthday)	If Under 1 Yea	8. Date of Bir		g.	Birthpla	ace (State or	Foreign		
	Director		264-88 - 3		□ M 2 X F	60	Yrs.	Months Days	s Hours	Min.	11/30/			Countr	NY	
	and show lat	or	Usual Residence of 10a. State	10b. County		10c. City	, Town or Loc	cation			-			10	d. Inside Cit	y Limits
	Maryla 28a-f otifiec	irect	MD	Howard		Wo	oodsto	ck							1 🗌 Yes	2 🔼 No
	with the	Funeral Director	10e. Street and Num 11049 D	oxberry (Circle			10f. Zip Code 21	163			_	Citizen of What Country? United States			
92	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status		12. Was Decedent Armed Forces? 1 Yes 2			Vas Decedent of Yes, specify Cu	Hispanic Ori ban, Mexicar		cify Yes or No- Rican, etc.)		Black, W	lace - American Indian, Black, White, etc.		
2-00	hours a natural' lical Ex	leted	3 Widowed 4	15. Decedent's Ed	Year or Dates.		16a. Deced	ent's Usual Occi	upation			16b. F	Specify: White 16b. Kind of Business/Industry			
121	ithin 72 ene. r than " the Med	Completed	Elementary/Secon	ndary (0-12)	College (1-4 or	5+)	life. DO	kind of work done O NOT use retire Teacher		t of worki	ng	I	Educat:	ducation		
nd 2	filed with tall Hygid of other event, t	Be	17. Father's Name (F					reduier			e (First, Middle,	Maiden	Surname)			
ryla	d Ment marke matic	To	Isaac M		- Driet		Elizabeth Puglisi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,							7: 0	4.1	
, Ma	and 2 sho Health an tem 27 is other trau		19a. Informant's Nar R. Paul		Jr. – husl	band		g Address (Street								
Baltimore, Maryland 21215-0036	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Mem. Park 20c. Location - City or Town, State 20p. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Mem. Park 20p. Place of Disposition (Name of cemetery, crematory or other place) 20p. Place of Disposition (Name of cemetery, crematory or other place) 20p. Place of Disposition (Name of cemetery, crematory or other place) 20p. Place of Disposition (Name of cemetery, crematory or other place)													
Balt	permit. Departr Import any inje		21. Signature of Fun	1 0	ð.			Name and Add								
			23a. Part UEnter th	ne disease, or com	olications that cause ne cause on each lin	d the death e.							JC CIC		Approximate	e ween
	Medical		Immediate Cause (F disease or condition resulting in death)		a. Meta Due to (or as	stali		ung (Lanc	er				15	Onset and D	nths
	Examiner q ausit	_	Sequentially list con	nditions.	b									_		
		mine	Sequentially list conditions, if any, leading to immediate outce. Enter underlying Cause (Disease or injury											1		
	e execucian and	edical Examiner	that initiated events c. Due to (or as a consequence of):													
760	cate b physic				d											
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	onths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregna Other (specify)	ncy				23d. Date of delivery Month Day Year			'ear
ls, P.O.	v requires that th been signed by should be detac	by	Part II. Other signific	cant conditions co	ontributing to death I	out not resu	ulting in the u	nderlying cause	given in Part	1.			use contribut			
Division of Vital Records, P.O. Box	rsician: The law reques certificate has beer director, page 2 shou	Completed									24a. Was auto perfo		prior deat	r to com	sy findings a	ause of
Ea	ysician: The la is certificate ha director, page	Be	25. Was case referre		112-1				Place of Dea	ath (Check			<u></u>			
Ţ	Physic this caral dire	2	1 Yes 2	No	Hospital: 1 Inpat		ER/Outpatien 28b. Time of	t 3 🗆 DOA O			me 5 🔀 Resi			pecify)		
o uo	ending eath. Ir: After he fune	ficate	1 Natural 2 Accident	5 Pending Investigation	(Month, Da		injury	wc	ork? Yes 2	. 1	zod, Describe i	now inju	ly occurred			
Divisi	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Il Certificate:	3 ∐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inj	ury - At hor c. (Specify)		eet, factory, office			28f. Location (City or Tov			r Rural I	Route Numb	er,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	(Check 2	Medical Exami	sician: To the best of ner: On the basis of e se Practitioner: To the	examination	and/or invest	igation, in my opi	nion, death o	ccurred at	the time, date a	and place	e, and due to	the caus	se(s) and ma	
_	To the virthing of the company of th	-	29b. Signature and to	tle of certifier	· Yann	M.T)	29c. Licer	ise number	7		29d. Da	ate signed (M	onth, D	ay, Year)	012
			30. Name and addres	ss of parson who c	completed cause of c	death (Item	23a) (Type, P	rint)	1 0	1 ~	7	1	M	I	1	24.4
			Mansha 31. Date filed (Month	11 H. Le	VILLE 650	of A	1114h	Chau	1053	7. 1	OWSO	ツノ	VIATI	aus	1 2/	204
	Stat Registra	e	Date med (Month)	SEP 152	011 2 June	W Solgiall	D. A	arke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 22 2011 10:25MA Helen Delores Weber Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c, County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day Ye Months Days Hours ^{co}Maryland 218-34-0124 75 1935 Director NOV. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2X No White Hall MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2121 Gibson Road 21161 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status injury or other traumatic event, the Medical Examiner Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3₺ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Department of Health and Should be Department of Health and Menta Important: If item 27 is marked any injury or other traumating once. 2 Michael H. Haviland Manie C. Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 W. Cloverdale Ave. Shrewsbury, PA 17361 Hammond E. Weber, Jr/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept Date West Liberty
U.M. Cemetery 26, 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) White Hall, MD 2011 ature of Furieral Se 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. Second St. New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Subarach disease or condition Medical resulting in death) Éxaminer aneurusw Sequentially list conditions, Examiner Due to for as a consequence of d any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performed eral Director; After this certificate I filled in by the funeral director, pag 2 🗌 No 1 Yes 2 NO Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital / No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier

15V

DHMH 17 Rev 7/2009

State

Registrar

N

Charles St

Balt

MD

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Wheatmar

31. Date filed (Month, Day, Year)

SEP 2 8 2011

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plenber 22, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Physician/ 1035 AM En Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Montgomery Olney Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 X F Months Director 515-16-3687 July 31 1925 Kansas Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 15311 Pine Orchard Drive #2K 20906 USA items death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc or þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White Completed 3 X Widowed 4 Divorced Year or Dates permit, Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John A. Baird Johanna Marie Kreihbel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Johnson/daughter 1954 Aquetong Rd. New Hope, PA 18938 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Woodbine, MD Final Journey Crematory 09/29/11 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lieense 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. MO1251 Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death DESPINATORY ARRES Pnysician/ Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ ate has been sign page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death. To the Funeral Director: After this 27. Mann eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Raphael Loutoby. M. D. 31.2 31. Date filed (Month, Day, Year) State 2 9

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Frsure All Copies Are Legible.

Amend 23a per med cert Golp. Frsure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene
Per ME G919 9/29/11 TI
Reg. No. 0 | 1 31027 Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 Day Peggy Janice Borkowski 3 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death RIGIONAL HICIMICO Medical SALISBURY 8. Date of Birth (Month, Day, Year) May 15, 1938 **Funeral** Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 1 🗆 M 2 🏝 F Days Months Min Hours 407-46-2151 Virgie, Kentucky 73 **Director** Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director r 28a-f s notified Maryland Dorchester County Cambridge 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 21613 United States 5238 Gallium Court Apt. 202 ral", or items ? Examiner mus death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married 1 Yes Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Nursing Home N/A House Keeper 07 Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Sumame) **Ienora Isaac** မ John Henry Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5238 Gallium Court Apt. 202 Cambridge, MD. 21613 item 27 Mr. Alan Randolph Borkowski. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town State County ₹ ĕ cemetery, crematory or other place)

Cedar Hill Cemetery Wednesday ò 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn, Maryland Sept. 07, 2011 Signature of Funeral Service Licensee Laffrey L. Gair, Sr. O. P. Name Address of Facility Afternatives Funeral and Cremation Center, P.A.

Lic. #00677

Lic. #00677

Lic. #00677 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Multi-organ system FAilure disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Acute blood loss anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that be introduced to the control of the control Vascular injury during abdominal Exami acute blood loss anemia aortic aneurysm repair burial-transi that initiated events resulting in death) Last and CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) nding physician ause as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 Yes 2 No Yes 2 No of after death.

Director: After this certific 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 🗶 No 5 Pending yascular injury during abdominal aortic aneurysm repair 2 X Accident 8/29/2011 Investigation 6 Could not be unk filled in by the 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number of Rural Boute Number, City or Town, State) 100 E. Carroll. St 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Funeral C hospital Salisbury, MD the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 10 29b. Signature a 29d. Date signed (Month, Day, Year) D62107 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dougue 31. Date filed (Month, Day, Year) Douglas Wilhite 100 E. Carroll St SALIBBUTY md. 21801 32. Reg State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Tames Buck, Sr. Physician/ Month **O**9 7:34PM Medical **Examiner** 4b. City, Town, or Location of Death Gilchriot Hospice Baltimore owson 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, 213.12. **Director** 1 X M 2 □ F 11/03/192 or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore Gwynn Oak 1 Tes 2 No 10e. Street and Number 10g. Citizen of What Country? 2 Retinue Court, Apt. 203 21207 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Police 12th arade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, John BUCK Amanda Howard 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trezeline D. Washington 9006 Lesan Road Randallstown MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Owings Mills, MD 10/04/2011 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 22. Name and Address of Facility Vaughn C, Greene Fluteral Stiller 8728 Liberty Road Randall Jawn MD 21133 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause Final Approximate Interval Between Onset and Death Nay-small cell h, sician/ Due to (or a, a consequence of): disease or condition resulting in death) YCAN Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown Certificate: To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b director, page 2 s autopsv 1 🗌 Yes 2 No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital Other 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury 2 No 2 | 3 | Accident Suicide Investigation 1 Yes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature a 29c. License number 27 2021 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST CHALLES W 6701 N towson 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 3:50 P ^M 2011 Sept Kathleen Dolores Barnes-Sanchez Medical 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Towson Gilchrist Hospice Center Year If Under 24 Hrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) . Social Security Number **Funeral** (Month, Day, Year) Davs Hours Min. Months Director 213-68-8022 1 M 2 50 F 58 Vrs Jan. 25,1953 Maryland Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b Counts 10c. City, Town or Location Director Bel Air MD Harford 1 Yes 2 X No 10g. Citizen of What Country? ь 10e. Street and Numbe 10f. Zip Code pe 23a Funeral United States must 21014 732 Danville Circle or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Bace - American Indian. 11 Marital Status Examiner Black, White, etc. þ 1 Never Married 2XXMarried 1 Yes 2X No If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working il Hygiene. Johns Hopkins life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Administrative Assistant University 12 Years Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ည Edna Binkowski George Straka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 732 Danville Circle Bel Air, MD Mr. Joseph A. Sanchez (Husband and 2 s Health item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or of 1 Burial 2 Cremation 3 Removal from State Sacred Ht. of Jesus Cem. 9/30/2011 Dundalk, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Juneral Service License Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) tali Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): and -trans that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death as been signed by the a should be detached Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Junknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed' 2 🗌 No 1 Yes certificate Yes 2 L 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes 2 110 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate; 28d. Describe how injury occurred eral Director; After filled in by the funer (Month, Day, Year) 1 Natural iniury work?
1 Yes 2 No 5 Pending death. ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after To the Funeral Direc determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and tit MD D71040

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State Registrar ARATHI

RALTIMARE

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2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUMAR

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTENBER Physician/ 5.25 PM Bolling Jacqueline Maxine 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Doctors Community Hospital Lanham 5. Social Security Number 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 24 Hrs. 8 Date of Birth Funeral 1 🗆 M 2 🗶 F Days Hours Min Jan. 28, 1938 New York Months **Director** 227-46-4891 Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 No Prince Georges Greenbelt MD ō 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be items 23a Funeral USA 20770 8234 Canning Terrace 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. o. by 1 X Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: "natural" Completed 3 Widowed 4 Divorced Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

I is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Julian Bolling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important If item 27 is. 1109 K Street, NE, Washington, DC Towanna Bolling/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 9/22/11 Silver Spring, MD Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austin Royster Funeral Home TVantaer 14th Street, NW, Washington, DC 20011 M00969 3821 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Arrhythmias Medical resulting in death) Examiner Coronary Artery Disease Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 XNo Day Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End Stage Renal Disease Dialysis Dependent 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an Congestive Heart Failure To the Hospital or Attending Physician: The law autopsy page performed? Yes 2 X No death? 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2**X** No 1 🗌 Yes မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No iniury X Natural Accident 5 Pending s after death.

I Director: Aft d in by the fur М Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature ar title c 29d. Date signed (Month, Day, Year) DO. D0058275 9.15.11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITS 308 GLENN DALE, MD30769 12150 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month Jenneane C. Bradford 201Ť Sept 12:30 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Randallstown 4c. County of Death Bal timore **Examiner** Seasons Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days 1 🗆 M 2 💢 F 78 213-32-3405 MD Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director ms 23a or 28a-f s must be notified 1 Yes 2 No Randallstown Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other trauman." 21133 USA 3942 Deer Trail Way 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 2 🗆 XIO Yes, Give 1 ☐ Yes 2 X No Specify Specify: African-American 3 ◯XWidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland 12th Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Minerva Richardson John Welling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Jenkins/ Sister 3942 Deer Trail Way, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🕅 Burial 2 🗌 Cremation 3 🗍 Removal from State 20c. Location - City or Town, State Date Holy Family Church Cem. 9-30-2011 Randallstown, MD Donation 5 Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. . Signature of Funeral Service Licer 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on a fork ine. Approximate Interval Between Onserand Death shock, or heart failure. List only one cause on Immediate Cause (Final anciente Physician/ disease or condition resulting in death) Medical e to (or as a consequence of): Examiner Sequentially list conditions if any leading to infractions cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 20 No Day Year Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 Director; After this certificate 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 WNo 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 2011 pt/person who completed cause of death/(Item 23a) (ppe, Print) 2835 Smitt State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 30 PM Physician/ Month Year RENNETT KEMBERLI 201 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death Howard Howard County General Hospital Columbia 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 1 □ M 2 🔀 Director 218-04-8308 1969 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2X No Howard Elkridge 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21075 USA 6712 Deep Run Parkway within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Education 12 Student any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Saundra Sue Reedy Jimmie Alan Collins permit. Page 1 and 2 should to Department of Health and Me Important; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6712 Deep Run Pkwy. Elkridge, MD 21075 Kendi Marie Bennett/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) final Journey Crematory 09/29/11 Woodbine, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYPOXEMIA SEVERE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PULMONARY EMBOU Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lined in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events HICPERCOAGULA BLE Due to (or as a consequence of): resulting in death) Last Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ASTHMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' UNCONTROLLED DIAKETES MELLITUE 1 Yes 2 Z 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examina? 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Acciden
Suicide Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0043462 SEPT 27,2011 wn

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State Registrar 31. Date filed (Month, Day Year)

DHMH 17 Rev 7/2009

HOSPITAL COLUMBIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WHAM BOY(E M) HOWAYD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 24, 2011 Physician/ John Thomas Brennan 12:40 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice @ GBMC Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours (Month, Day, Year) **Director** 215-30-0921 1 XM 2 □ F Yrs. Sept. 1, 1933 78 Maryland Usual Residence of Deced items 23a or 28a-f shov ner must be notified at 10b. County 10d. Inside City Limits 10c. City. Town or Location the Maryland Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1802 Fallstaff Court 21015 USA Page 1 and 2 should be filed within 72 hours after death \u00fanti of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

XYes 2 \(\sum \) No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify. Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Thomas Herman Brennan Bernadine Mae Boyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Kreugh E. Brennan / Wife 1802 Fallstaff Court, Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 9-29-2011 Towson, Maryland Hilltop Service Corp: 21. Sign ure of uneral price Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph sician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to for as a consequence on If they, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ **Hospital or Attending Physician:** The law requires that the death 24 hours after death. in the past 12 months? Pregnant at time of death 2 No g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 10 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 B-16 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this (letely filled in by the funeral dii 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ti∤le of certif 29c. License number 29d. Date signed (Month, Day, Year) D71040 qx1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SI SUTTE 4105 701

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 31034 For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Seasons Hospice at Northwest Hospital Randallstown If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) 83 **Director** 220-24-3107 1 XM 2 □ F 01/13/1928 Maryland Usual Residence of Deceder show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 No Anne Arundel Brooklyn 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a USA 21225 915 1st St #2 and 2 should be filed within 72 hours after death Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, "natural", or iten edical Examiner Armed Forces? 1950 Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give Year or Dates 1952 Specify 3 Widowed 4 Divorced Completed and Mental Hygiene.

is marked other than "natur aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) none disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Goldie Fleagle ortant: If item 27 is marke injury or other traumatic Lawrence Edward Bond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21228 Melissa Goldberg - granddaughter Marathon Ct; Catonsville, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Department of I Important: If its any injury or of Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami use as the burial-tran and Due to (or as a consequence of) nding physiciar Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No õ Pregnant at time of death Month Day Year 5 Other (specify) ed by the a detached i P.O. signed to be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, cate has been sig r, page 2 should b 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy perform certificate 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ည this (1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Dear 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation within 24 hours after death

To the Funeral Director: /
completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

29b. Signature and title of certifie

within 7

cause of death (Item 23a)

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Suptember 27 2011 Physician/ 130AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Burnie Anne Arunde Washington Medical Glan Baltimore If Under 1 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F 08/15/1966 Mary land 45 Yrs. Director 218-86-4339 Usual Residence of Decedent octant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 1 X Yes 2 No MD Anne Arundel Annapolis 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral U.S.A. 159 Brightwater Drive 21401 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 X Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 9 Automotive Care Auto Detailer Be pe filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Rice William C. Butler Marnette Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7770 Odell Morten Road, Glen Burnie, MD 21060 James Roman Butler, Jr. / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 09/28/2011 Hanover, Maryland 21. Signature Muneral Service Lice 22. Name and Address of Facility Anatomy Gifts Registry MD 21076 7522 Connelley Dr., Ste. P, Hanover, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List Immediate Cause (Final Sepsis Physician/ disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and a betached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 3 Probably 4 Unknown been : 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy this certificate has page 2 1 ☐ Yes 2 🔀 filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: ျှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred thin 24 hours after death. the Funeral Director; After injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 3 🗀 only one within To the

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Butler

Registrar

29b. Signature

Registrar's Signature

682

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar	yland /		irtment of F tificate of D			Reg. No.		31036		
	Physicia	in/	Decedent's Name (First, Middle, La.	st)					2. Date of Dea	th	Year	3. Time of Death		
	Medic	cal	MOLLTE 4a. Facility Name (if not institution, give		BLOOM		4. 61. 7	Landing of Davids	SEPTEMI	BER 25,	2011	4:25 P ^M		
	Examir	ner	ENVOY OF PIKES	,			BALTIN	Location of Death			4c. County of Death BALTIMORE			
	Funeral	Г	Social Security Number 6. S		n yrs. last bin		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl	9. Birthplace (State or Foreign				
	Director		215-09-5746 Usual Residence of Decedent	LIVI ZALIF	97	Yrs.	monaio sey		07/18/	1914		MD		
	land show dat	tor	10a. State 10b. County	1	0c. City, Tow	n or Loc	ation				1	0d. Inside City Limits		
	Mary 28a-f otifie	Director	MD BALTI	MORE	LU	THE	RVILLE					1 Yes 2 No		
	ith the 23a or st be r	ral	10e. Street and Number	COURT			10f. Zip Code	100		10g. Citizen of		ntry?		
	eath w	Funeral	13 DIPPING POND 11. Marital Status	12. Was Decedent Eve	r in U.S.	13. W	210 Vas Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	14. Rac	USA ce - Americ			
36	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married	1 Vec 2 XNo			Yes, specify Cuba ☐ Yes 2 X No	Hican, etc.)	Black, White, etc. Specify: 1,74777					
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215	in 72 h e. han "r	duic	(Specify only highest gr Elementary/Seconday (0-12)	ade completed) College (1-4 or 5+)		(Give k	ind of work done of NOT use retired)	luring most of work	ing					
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lanc	be file ental } 'ked o ic eve	To	PHILLIP	ME	Т <i>7</i> .			18. Mother's Nam ESTHER	e (First, Middle, i	vialden Surriam		NOWN		
lary	should and M is mar		19a. Informant's Name/Relationship (7			. Mailin	g Address (Street a	and Number or Rura	al Route Number	; City or Town, \$				
€,	and 2 stealth		SHELDON BLOOM/S	1				OND COURT				21093		
nor	age 1 ant of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Domoval from State	cemete	rv. crem	sition (Name of eatory or other plac R BENEFT (e) CIAL 09/2	Date 0 / 2 0 1 1	20c. Location	•			
Baltimore, Maryland 21215-0036	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other:		21. Signature of Funeral Service Lice	ny)	CIRCLE			ss of Facility SO		BALT:				
m	20 E # 9							TERSTOWN			LE, M			
	Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition		ie death. Do i		W .	such as cardiac o		est,		Approximate Interval Between Onset and Death ———————————————————————————————————		
	Medical Examiner		resulting in death)	Due to (or as a c	onsequence	of):						/		
	D 45	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter orderlying	b. Due to (or as a c	onsequence	of):								
	icate be executed physician and s the burial-transit	Exan	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of):											
0	e be ey ysician e buria	ical												
8760	rtificate ing phy e as th		IF FEMALE:											
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at til 9 Unknown	Fetal deat		Ectopic pregnand Other (specify)	У			ate of delive onth	ery Day Year		
P.0	that the	by Pl	Part II. Other significant conditions of	ontributing to death but	not resulting	in the ur	nderlying cause giv	ren in Part I.	23e. Did to	bacco use conf	ribute to th	ne cause of death?		
rds,	een sig ould b	ted							1 🗆 `			bably 4 Unknown		
Reco	The law noate has book page 2 sh	Completed							24a. Was a autop perfo	rmed?		psy findings available mpletion of cause of		
ita	sician certifi irector) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🖾 No	Hospital:	- O		Othe	ace of Death (Checker:						
on of \	nding Phy tth. : After this e funeral d	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 28a. Date of injury (Month, Day, Y	28b.	Itpatien Time of njury	28c. Injury work		28d. Describe h			<i>)</i>		
Division of Vital Records,	al or Atter s after des al Director ed in by th	Certificate:	3 Suicide 6 Could not b 4 Homicide determined			rm, stre	et, factory, office	//-	28f. Location (S City or Tow		er or Rural	l Route Number,		
	the Hospit in 24 hour the Funera	Medical	(Check 2 Medical Exam	sician: To the best of my iner: On the basis of exar se Practioner: To the be	mination and/o	or investi	gation, in my opinio	on, death occurred a	t the time, date a	nd place, and du	ue to the ca	use(s) and manner stated.		
	To To con		29b. Signature and title of certifier	5			29c. License	number D375		29d. Date signe		Day, Year)		
				brit Mt	th (Item 23a) (78	35 5	ath A	we 1	battin	a N	boziz qu		
	Stat Registra		31. Date filed (Month, Day, Year) SEP 2 9 20	37 Registrar's	Signature	ba	Kal							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:52m 2/4/14/26 Mai Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Kandails town Spita thurst If Under 1 Year If Under 24 Hr 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** . M 2 □ F Months Days Hours Min. (Month, Day, Year) 04/02/1929 Country) Director 188-22-3274 82 Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Tes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9450 WORDSWORTH WAY, #401 21117 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. \$ 1 Never Married 2 X Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates permit. Page 1 and 2 should te filed within 72 hours Department of Health anc Mental Hygiene. Important, If item 27 is neared other than "natur any Injury or other traun atip event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **GROCERY** MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEWIS BERMAN ROSE SUGAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARILYN BERMAN / WIFE 9450 WORDSWORTH WAY, #401, OWINGS MILLS, MD Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) OHEB SHALOM MEM. PARK 09/28/2011 REISTERSTOWN, MD 21. Signature of Funeral Service License e 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Monain RLi Millechall disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dicusetts bequaritially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine ty perfension 2005 and-tran Due to (or as a consequence of) resulting in death) Last bunial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending physi IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No the 9 Unknown 9 Unknown Records, P.O. by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed has page this certificate 2 No 1 Yes Yes Division of Vital 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner Hospital: Other: 1 Tes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work 1 🗌 Yes 2 🗀 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident М Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

29

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Sept Physician/ 2011 1:45 P M Atlee H. Conaway, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Edenwald Towson g. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year)
Oct. 18, 1921 Maryland **X**XM 2 □ F Director 216-12-8060 Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XXNo MD Carrol1 Finksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21048 U.S.A. 2044 Kays Mill Rd. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc à 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates WW II White Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than should be filed within 7 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Margaret Buckingham Atlee H. Conaway, Sr. Page 1 and 2 should be nent of Health and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21048 19a. Informant's Name/Relationship (Type, Print) 2044 Kays Mill Rd. Finksburg, Maryland If item 27 Barbara L. Conaway / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Providence Church Department o any injury or 4 ☐ Donation 5 ☐ Other (Specify) 9/30/11 Gamber, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 1605 Reisterstown Rd. Owings Mills, MD 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence as the burial-transit that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No ò Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ The law requires 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: Certificate: To Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred or Attending Natural 5 Pending 1 Tes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only or 29b. Signature and title of certifier 30. Name and add ess of person who 5t MAR State

DHMH 17 Rev 7/2009

Registrar

3altimore.

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20118:25 PM Sept 26 Elaine Christensen <u>Barbara</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Forest Hill Health & Rehab Forest Hill If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 M 2 X F Days Hours 12/09/1935 Maryland Director 220-34-6470 75 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Fyamina most han a state of the state 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 K Yes 2 No MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3218 Wilson Avenue 21009 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robinson Dorothy L. Willard G. Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey Street, North East, MD 21901 <u> Shirley Laird / Sister</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 09/28/2011 Hanover, Maryland Anatomy Gifts Registry 21. Signature uneral Service Lice 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition re Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 032257 Septimbe- 27, 2011

State Registrar LITW. Mochha

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Anthony Charles Cirincione, Sr. September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral ¹X X**M 2 □ F Min. Months 7/10/1931 80 Days Hours 215-28-9553 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Abingdon 1 Xes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2411-A Old Emmorton Rd. 21009 permit. Page 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musones. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give 1952-53
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married SpecifyWhite Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ϊ No Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clothing Retailer Garment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jennie Barranco Dominic Cirincione 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Kensington Pkwy, Abingdon, MD Mark Cirincione / 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/27/2011 Aberdeen Harford Mem. Gdns 4 Donation 5 Other (Specify) 21. Signature of Funeral 8 22. Name and Address of Facility
Tarring-Cargo Funeral Home,
333 S. Parke St, Aberdeen, N Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Conth monar Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? į Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown should be detached 9 Unknown signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a Was an page 2 s autopsy performed? leath? I¥Yes 2□No 24 hours after death. Funeral Director: After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: ဂ္ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of gertifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician /Medical Examiner The law requires that the death certificate be executed burial-tran attending physician Division of Vital Records, P.O. Box 68760 as the l for use

Funeral

Director

Items 23a or 28a-f show ner must be notified at

Examiner

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Department of It important: If Ite any injury or ot once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

signed by the at ald be detached f director, page 2 should completely filled in by the funeral

certificate

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificat

To the within 2

25 V

ģ Completed

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (check only 29b. Signature and title of certifier

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Maria Cettomac, MD

6 Could not be determined

29c. License number RES-DUC

29d. Date signed (Month, Day, Year) September 25, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deanna Cettomai, MD

4940 Eastern Avenue, Baltimore, MD, 21224

State Registrar

cal

31. Date filed (Month, Day Year)

DHMH 17 Rev 1/2001

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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			State Registrar				Cei	rtificate of	Death			Reg. N	201		31042		
П	Physicia			Decedent's Name (First, Middle, Last) Frank C. Donahoe							2. Date of De Month Septemb	^{1y} 6 20	ear 1	3. Time of Death 12:20 AM			
3.0	Medio Examir		4a. Facility Name (if			er)		4b. City, Town	or Location		pepceme		. County of		12.20		
المساساة		Gilchrist Hospice												ltimore			
10	Funeral Director		5. Social Security No. 418–20–(5. Sex 7 1 X M 2 □ F	. Age (In yrs.		If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. (Month, D				irth 9. Birt Pay, Year) Coυ			place (State or Foreign itry)		
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	or 28a	Director	MD 10e. Street and Num	nber]	Baltimo	10f. Zip Code				10° Ci	tizen of Wha	nt Cour	1X Yes 2 ☐ No		
	with ti	Funeral			enue Rd.			2121				_	USA	ii Oodi	Tu y :		
980	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 1 ☐ Never Marri 3 ☐ Widowed	unk led 2 🗆 Marrie	12. Was Deced	es?	1942	Was Decedent of f Yes, specify Cu			cify Yes or No- Rican, etc.)		14. Race - Black, Specify:		etc.		
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Maryland 21215-0036	led within 7 Hygiene. other than ent, the M	Completed	Elementary/Seco	ondary (0-12)	College (1-4	or 5+)	life. DO NOT use retired) assemblyman					General Motors					
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yla		욘	James E				,		Br	ook W	lalace						
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Baltimore,	permit. Page Department Important: I any injury o		21. Signatur Fur	peral Service Lis	en	irecto	y 22	2. Name and Add							21201		
			23a. Part 1. Enter the shook, or hear	he disease, or c t failure. List on	omplications that ca ly one cause on each	used the deat line.	h. Do not ente	er the mode of dy	ing, such as	s cardiac o	r respiratory ar	rest,			Approximate Interval Between		
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876	tificate ng phy e as th	Med	IF FEMALE:														
Box 68760	nat the death certificate be executed do by the attending physician and detached for use as the burial-transit	Physician/Medica	23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?	1 ☐ Live Bi 4 ☐ Pregna	. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown							23d. Date of Month		ery Day Year		
ds, P.O.	requires that been signed t should be det	þ	Part II. Other signifi	icant condition	s contributing to dea	th but not res	sulting in the u	inderlying cause	given in Part	t I. ——					he cause of death?		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Completed	Somplet	Complet									24a. Was auto perfo 1 \square Yes	psy ormed?	prio dea	r to co th?	psy findings available mpletion of cause of 2 No
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n of V	ding Phys h. After this funeral di	ate: To	27. Manner of Death	5 Pending	28a. Date of (Month,		28b. Time of injury	ent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ho 28d. Injury at work?					Hospice				
ivisio	or Atten	Certificate:	2						Yes 2		28f. Location (S City or Tov		eet and Number or Rural Route Number, State)				
Ω	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2	Medical Exa		of examinatio	n and/or invest	tigation, in my opi	nion, death o	occurred at	the time, date a	and place	e, and due to	the cal	use(s) and manner stated.		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month LIA Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 9 Norham Ct #F Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Months Days Hours Min **Director** 201-24-4536 1 XM 2 ☐ F 76 Yrs 07/20/1935 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at rector 28a-f 1 X Yes 2 ☐ No MD Baltimore ā 10e. Street and Number 10g. Citizen of What Country? ŏ 10f. Zip Code "natural", or items 23a or edical Examiner must be i Funeral 21221 USA 9 Norham Ct #F permit. Page 1 and 2 should be filed within 72 hours after death vipperatment of Health and Mental Hyglene.
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9 Norham Ct #F; Baltimore, MD 21221 Kelly Dimitris - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 🗀 Cremation 3 🗔 Removal from State cemetery, crematory or other place) X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Foard neral Ser 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 449 C disease or condition Medical resulting in death) Due to (or as a onsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

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1 ☐ Yes 2 ☐ No Month Dav Year signed by the al 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably Onknown been sig should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

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State Registrar 29b. Signature and title of certifie

30. Name and address of persor

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31. Date filed (

who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4a Per PHY G919 9/29/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 2011 11:13 PM Floris Davisson Spetember Medical 4a. Freitty Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Roder Wood Renaissance Gardens Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days 1 🕱 M 2 🗆 F Months Hours 047211 1925 West Virginia Yrs. 86 Director 235-34-0202 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location be notified at Director 1 Yes 2 No Silver Spring MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 23a Funeral 3124 Gracefield Rd Apt 205 Examiner must items 12. Was Decedent Ever in U.S.

Armed Forces?

1 🖾 Yes 2 🗌 No 1943If Yes, Give 1946 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. or j 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify Specify: "natural", 1946 3 Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene.
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1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Į Pregnant at time of death be detached the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, chronic kidney disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 🗓 No 1 Yes 2 X No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier コマ 1581de1 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gracefield Rd; Silver Spring, Maryland 20904 Eileen Gemmell 3160 32. Registrar's S State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 22^{Day} 0^{Month} Physician/ 20 gar Marsha Ann Dixon- Bev 9:00A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 829 N. Bentalou N/A Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 □ **F** 212-40-0729 04729/ 7941 Marviand Director 70 Usual Residence of Decedent shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director MD N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 829 N. Bentalou St. 21216 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ural", or iten | Examiner þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", Specify: Black Completed 3 - Widowed 4 - Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) yrs. Absent Parent Locator State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jessie P. Parker Marlene Revell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 829 N. Bentalou St., Baltimore, MD 21216 Orin Tynes-Bey(son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cem. 09/27/11 Baltimore,MD Signatule of Funeral Service Licensee Josephoda: Funeral Home 2140 N. Fulton Ave., Baltimore, MI Baltimore, MD 21217 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician, metastatic cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa. Enter endanying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 🗆 Other (Specify) Hospital: 2°No မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled i Medical 1. 😿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Michael R. 9 MD Res - 000 September 23, 2011

DHMH 17 Rev 7/2009

State

Registrar

401 North Broadway, Room 1363, Baltimore, MD 21231

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Michael R. Granwald
31. Date filed (Month, Day, Year)

SEP 2 9 2011

OV

Registrar
DHMH 17 Rev 1/2001

State

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Bu) Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3 1 0 4 7 State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 19 2011 Physician/ 4:05 Ам James Austin Everman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Laurel Cherry Lane Nursing Center 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Sex 1 X M 2 □ F Days Hours Min. MIT 117 1918 Kentucky **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director MD Prince Georges Laure1 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9001 Cherry Lane 20707 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) self employed restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Everman Emma Boaz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sk Department of Health a Important: If item 27 is 13145 NW 11th P1; Sunrise, Florida 33323 Dorothy Pace - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part a Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ elio disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that infitiated events Examine requires that the death certificate be executed Due to (or as a conseque resulting in death) Last attending physician a for use as the burial-Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 Yes 2 Lg Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌠 Unknown 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law prior to completion of cause of death? autopsy page performed Yes 2 1 Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural Pending 1 🗌 Yes 2 🗌 No 2 Accident Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Selth. 22% 29b. Signature and title of 002472 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOWIE St 208 LAUREL State Registrar

Box 68760

P.O. |

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#16bperin g919 9-29-11 d.o. State of Maryland / Department of Health and Mental Hygiene 31048 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year 26, 201 Ethelene D. **Edwards** Month plemser Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital P.G. Lanham Social Security Numbe If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🏋 Days Hours Min 579-06-4084 86 (Yontb 28, Y25 Director Guyana Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 10d. Inside City Limits P.G. Bowie MD. 1¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20720 11203 Lake Victoria Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 ₩idowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Alexander Jones Ruth Hope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 Pamela Reddock/Daughter 10900 Sebago Ct. Upper Marlboro, Md. Rosignol W. Bank 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Viaage Berbice 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 10/8/11 Rosignol Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signat of Funeral Service Licens 22 Hackette sa Funeral Chapel, Inc. uto Hac 814- Upshur Street, 20011 W. Ď.C. NW Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-transit mI attending physician and for use as the burial-trar Due to (or as a consequence of resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Year Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 Tyes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending hours after death. Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) MDD 58182 2011 30. Nappe and address of person who completed cause of death (Item 23a) (Type, Print) 20170 SOITE 101A GREENBELT MD

State

Registrar

1500

GEORGE

1. Date filed (Month

SEP 2 9 2011

M.O.

HANOVER

ALKWAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 31049 Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ SEPTEMBER Medical 2 4a. Facility Name (if ot institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE OF BALTIMORE Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 217-70-176 Hours Month. Day 1 M 2 F Director 01 Ш or 28a-f show 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at **Funeral Director** 10d. Inside City Limits 1 ¥Yes 2 ☐ No ROGER Mor 10f Zin Code 10g. Citizen of What Country? , or items 23a 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Black, White, etc. Completed by 1 Yes 2 No Specify. "natural". 3 Widowed 4 Divorced If Yes, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' (Secondary (0-12) College (1-4 or 5+) アンローノ アカリア ommunication Be Laone 19a. Informant's Name/Relationship (Type, P nt) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٥ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 10 011 21. Signatur o Funeral Service Licensee Funeral Home Eary Mo 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ SEVERE METABOLIC ACIDOSIS disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** HUPOTEN SION DAY Sequentially list conditions. Examine I any, leading to immedicause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE nse s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month detached 1 Yes 2 L by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEART DISEASE 2 No 3 Probably 4 Unknown has been 2 ONE 24a. Was an . Were autopsy findings available prior to completion of cause of performed No death? After this certificate 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) 2 No မ Other: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Tyes 2 🗌 No Investigation within 24 hours after death

To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 000 2 SEPTEMBER 25 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL BALTIMORE OF HATIA SINAI State SEP 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Richard ENG LAND 9:050 September 70011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Milford Manor Nursing Home Pikesville Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) UNK Min. (Month, Day, Year) **Director** 419-30-6168 82 1 XM 2 □ F 01/31/1929 shov 10b. County 10a. State death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 H Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 5250 St. Charles Avenue "natural", or items 12. Was Decedent Ever in U.Sunk 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinone. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 black 3 Divorced 1 ☐ Yes 2 XNo Specify: Year or Dates 16a. Decedent's Usual Occupation unk 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rugal Route Number, City or Town, State, Zip Code) Balto County Dept of Aging 611 Central Ave; Towson, MD 21204 <u>Yolanda Dorsey - legal guardian</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 【XOther (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician End-Strat disease or condition resulting in death) Cardionyopath Medical Due to (or as a consequence **Examiner** Sequentially list conditions, cause. Enter Underlying Due to (or as a nonsequence of) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): attending physiciar Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ō in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 s or Attending Physician: The law autopsy performed Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Patural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Ms Ryapalnem. D 29d. Date signed (Month, Day, Year)

State Registrar 2835 Smin AV 5203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

N-S. Rajnpakseim.D

31. Date filed (Month, Day, Year) SEP 2 9 2011

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9/122/11

11-07072 Samuel Epps Please Type or Print in Black Indalible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 3 1 0 5

amuel Epps	1- For State	tate of Maryland		ent of Health a lite of Death	ing Mental n	ygiene Reg.	201	1 3105	
Physician	Registrar 1. Decedent's Name (First, Mid	dle,Last)				2. Date of Death		3. Time of Death	
Medical Examine						Month E September		0055 hrs	
	4a. Facility Name (if not institut Harford Memoria! Ho			4b. City, Town, Havre De	or Location of Death Grace	1	4c. County of Dea Harford	tri	
Funeral	5. Social Security Number		e (In yrs. last birth			_	(MM/DD/YYYY) 9. B		
Director	216-68-4505								
kus	10a. State 10b. County	,	10c. City, Town	or Location				10d. Inside City Limits	
and show	MD N/	Α		Balt	imore			1 X Yes 2 No	
the Maryland a or 28a-f sho	10e. Street and Number			10f. Zip Cod		109	. Citizen of What Co U . S		
		12. Was Decedent		13. Was Decedent of			14. Race - Ame	erican Indian, Black,	
or items 23	1 Never Married 2	1X Yes 2			ban, Mexican, Puerto	Rican, etc.)	White, etc.		
s after ral", niner	3 Vidowed 4 X D	ivorced If Yes, Give Year or Dates:	noleted) 16a [1 Yes 2 🛣		work done I1	Specify: 16b. Kind of Busines	Black s/industry	
2 hour	Elementary/Secondary (0-12			luring most of working					
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	2 years		Nu	rsing			shock Ti	cama	
11215-0036 Id be filed within 72 hours a fornal Hygiene. narked other than "natura event, the Medical Examin						e (First, Middle, Ma	aiden Surname) e Brogdoi	n	
D 21215-(should be filed and Mental Hyg T is marked oth			19b	. Mailing Address (S	_				
Baltimore, MD 21215-0036 oemit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than mijnry or other traumatic event, the Medical To Re Commit	Magnolia Epp	s Bass(mot						e,MD 21223	
or Heal	20a. Method of Disposition 1 Burial 2 Crematic	on 3 Removal from St	ate cremato	f Disposition (Name of ary or other place)			20c. Location - City		
timent or react	4 Donation 5 Other	Specify:	on-si	te Crema			Baltimo		
Baltimo permit. Page Department o Important: injury or oth	21. Signature of Funeral Service	e Licensee	Jano	2140 N.	Fulton	Jr. Fu Ave., B	neral Ho Baltimor	ome PA e,MD 21217	
Physician	23a. Part I. Enter the disease, of failure. List only one cause		the death. Do no					Approximate Interval Between Onset and	
/Medical	Immediate Cause (Final diseas	se a. Septic		ry Emboli				Death	
	or condition resulting in death)	Dao to (o. 10 1 01.11	equence of): Foot Inj	urv					
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60, tre be executed hysician and burial - transit	<u> </u>	d	1 07 0		000 10	10 11 .			
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transformulated by Dhysician/Madical E	X UNPENDED			8a-f per m	e g920 10-	-13-11 Vt			
876 tificate ng phy as the l	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, outcome the	ne of pregnancy 2	Fetal death	3 Ectopic pregna	ancy	23d. Date of deliver	Day Year	
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tal Reco	Ę –					perform 1 ✓ Yes 2			
Vital F ysician: 'ysician: his certific director, p		T. C. C. C.			ace of Death (Check				
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on of anding Phart. or: After the funeral	1 Natural 5 Pe	nding Tunkmour		nown 1	Yes 2 🗷 No	subject	stubbed	toe	
Division pital or Attendio ours after death. filled in by the fu		estigation		rm, street, factory, offic	ce building, etc.		reet and Number or	Rural Route Number, City	
Spital Di	4 Homicide de	ermined (Specify)	unknov			unknown			
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	29a. Certifier (Check only one) 2 Medical Expression 29b. Signature and title of certification 29b. Signature and title of certification 29b. Signature 20b. Signature	Physician: To the best of management of the basis of examiner: On the basis of example of the basis	y knowledge, dea mination and/or ir	th occurred at the time evestigation, in my opin	e, date and place, and nion, death occurred	d due to the cause at the time, date ar	(s) and manner as sind place, and due to	the cause(s)	
To viti	29b. Signature and title of certi	and manner stated.			ense number		29d. Date signed (M		
	(ande	Halla	u	Ο.	C.M.E.		September 23,	2011	
7	30. Name and address of personal Carol Allan, MD	on who completed cause of o		V. Baltimore Stre	et, Baltimore, M	1D 21223			
Stat	31. Date filed (Month, Day, Yea	r) 32. Registra	r's Signature	harry					
Registra	SEP 29	CUII Severa	1 13.14	Marie Comment	<u> </u>				

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#21perfn 9919 9-30-11d of State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Best Care Assisted Living Reisterstown Baltimore Co. 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth
(Month, Day, Year)
Feb. 10,1920 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Hours Min. Director 213-07-0408 91 Feb. Maryland Usual Residence of Decedent 28a-f show 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD Baltimore Reisterstown 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 639 Main Street 21136 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 2X No 1 ☐ Yes 2 ☐XNo Specify: Completed 3 Widowed 4 Divorced Specify White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Co. Schools 12 Years Cashier Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) ၉ Josephine Peterson Charles Noplosh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip A. Gribaudo (Son) 3636 Sussex Road Gwynn Oak, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Stanislaus Cem. 10/1/2011 Baltimore, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland Michael Neiser per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ceveliovascular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to immediate ner Due to for as a consequence of, cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: cate has been signed by the attendin page 2 should be detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Day 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> law requires Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 2.2 No or Attending Physician: The rector, 25. Was case referred to medical Assisted Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No within 24 hours after death.

To the Funeral Director: After this c completed filled in by the funeral directors. ဂ Living Ctr 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 28d. Describe how Injury occurred 5 Pending injury Accident Investigation Suicide
Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 26434 person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Year **Physician** 2011 /Medical 4a. Facility Name (If not institution, give steet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Riverview Nursing Home Essex 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. 1 **M** M 2 □ F Months Days Hours 86 217-16-8406 Director Maryland March 9,1925 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at Director Elkridge 1 ☐ Yes 21 No MD Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 United States Funeral Apt. 120 6391 Rowanberry Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ If Yes, Give Year or Dates: 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify <u>≨</u> Specify: 3- Widowed 4 □ Divorced White WWIT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, The M College (1-4or 5+) Sherwin Williams Safety Coordinator 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blanche Allender Oliver Griffith ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1333 Broening Hwy. Baltimore, Maryland 21224 Dorothy Jackson (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 9/28/2011 Towson, Maryland 4 □ Donation 5 ☑ Other (Specify) 21. Signature of Fundrel Service La 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to minimal decause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a I □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been sal director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform 2 No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Hospital Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

30. Name

Yea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cilles 1904 PM Mark September 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University Mamland Medical Center 04 Baltimore Social Security Number **Funeral** If Unde Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Hours 215-58-1751 **Director** 59 Maryland Usual Residence of Decedent 28a-f show Director 10a. State 10b. County "natural", or items 23a or 28a-f sho with the Maryland 10c. City, Town or Location 10d. Inside City Limits MD Cecil 1 Yes 2 No Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32 Leeward Court USA 21921 Page 1 and 2 should be filed within 72 hours after death next of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armyd Forces?

1 1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify. 3 Widowed 4 M Divorced Specify: Black Completed Year or Dates er than "natur, 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Grade Carpenter Private Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Mitchell Wade Emma Giles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julius J. Giles - Son 32 Leeward Court Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 M Cremation 3 ☐ Removal from State Department or Important: If any injury or 9/27/2011 4 Donation 5 Other (Specify) Green Mount Cemetery Baltimore, Maryland ture Funeral Service Licensee Chatman-Harris Funeral Home 4210 Belair Road Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Schemic Heart Discase Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician anu I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Heart Failure 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available To the Hospital or Attending Physician: The law this certificate has prior to completion of cause of death?

1 Yes 2 No page 2 autopsy performed? Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No မ 1 🗌 Yes 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗐 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 NPI 1578798310 22 50P TI of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

CED 2 0 2011

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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St.

Baltimore, MD

		•	FOI	rtificate of Death		g. No.						
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	23 2011 3. Time of Death						
- 12	Medic	al	Madeline Gibson 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	sept.	23 2011 6:05 p ^M						
	Examin	er	Gilchrist Hospice	Towson		Baltimore						
1.5	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Y	th 9. Birthplace (State or Foreign						
	Director		-,21.7-24-281.7 1 □ M 2 🗹 F 81 Yrs.	Working Days Flours Will.	March 15,							
	nd how at	J.C	Usual Residence of Decedent OT 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits						
	/laryla 8a-f s tified	Director	MD N/A Baltimore	Э		1 Yes 2 □ No						
	the Na or 2	io le	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?						
	ns 23 must	Funeral	2420 E. Hoffman Street	21213		USA						
	r deat or iter niner i	by Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.						
036	s afte ral", c Exan	q pe	3 Widowed 4 Divorced Year or Dates.	1 ☐ Yes 2 ▼No Specify:		Specify: Black						
21215-0036	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work	ing 1	6b. Kind of Business/Industry						
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lan	d be fi dental rrked tic ev	၉	Bruce Hill	Mary Lo	ng							
Maryland	12 should be file lith and Mental H 27 is marked or r traumatic eve		1	ling Address (Street and Number or Rur								
	and 2 Health tem 27 ther tr		Gregory Leavy - Nephew 41 0 20a. Method of Disposition 20b. Place of Disp	Chelmsford Court M		Oc. Location - City or Town, State						
nor	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hydjene. ordrant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.e.		1 M Burial 2 Cremation 3 Removal from State cemetery, cre	ematory or other place)		Arbutus, Maryland						
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.	1		22. Name and Address of Facility Ch								
<u>~</u>	Dep Imp any	(2)	Jullen Harris	5240 Reisterstown	Road Balt	imore, MD. 21215						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
1 m. 1	Medical	1	Immediate Cause (Final disease or condition resulting in death) a. Dues (gross consequence of):									
-	Examiner		Due to (or as a consequence of):	was alimber	· laset	14911						
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
	cuted nd transit	Examiner	Cause Enter Underlying Cause (Disease or injury that initiated events c.									
	cate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):									
190	ficate be executed g physician and as the burial-transi	Physician/Medical	d									
89	eath certific attending I for use as	M/ne	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy		23d. Date of delivery						
Вох	Attending Physician: The law requires that the death certif ar death , ar death , ar death . After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	sicie	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year						
P.O.	that the deaned by the and by the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?						
S, D	signe d be d	d by			1 ☐ Yes	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known						
ord	v require been si should	lete			24a. Was an							
3ec	The law ate has page 2	Completed			autopsy perform 1 Ves 2	ned? death?						
a	ysician: The nis certificate I director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec								
Ξ	Physic this ce	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			nce 6 Dother (Specify) HOXP						
n o	ding I th. After funer	cate	1 Natural 5 Pending (Month, Cay, Year) Injury	work? M 1 Ves 2 No	28d. Describe hov	v Injury occurred						
Division of Vital Records,	I or Attendii after death. Director: Ai d in by the fu	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s		28f. Location (Stre City or Town,	eet and Number or Rural Route Number,						
Θį	ital or irs afte al Dir led in		4 - Homiciae aeterminea building, etc. (Specify)									
^	Hospital or 24 hours afte Funeral Directely filled in	Medical	29a. Certifier (Check 2 Medical Examiner: On the bast of my knowledge, death	estigation, in my opinion, death occurred a	at the time, date and	I place, and due to the cause(s) and manner stated						
U -	To the Hosp within 24 ho To the Fune completely f	Σ	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and the of certifier	29c. License number		od. Date signed (Month, Day, Year)						
	->-0		I phales Mr	D 71046	,	9/24/11						
	γ		30. Name and address of person who completed cause of death (Item 23a) (Type									
	0			HARLES ST	SUITB 41	OF BACTEMORE MD						
	Sta Registra		31. Date filed (Month, Day, Year) 2. Registrar's Signifure	Med								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Wayne G		nwalt 1- For State Registrar	State of Maryla		artment of ertificate of		Mental I		eg. No. 20	11 3105
Physicia Medical Examin	n/	Decedent's Name (First, I ROBERT	Middle,Last) WAYNE	GREEN	WAT.TT	· · · · · · · · · · · · · · · · · · ·		2. Date of Dea		3. Time of Death 2246 hrs
		4a. Facility Name (if not institution, give street and number) Northpoint Boulevard & Entrance to Eastpoint Mall Dundalk					Location of Dea		4c. County of	
Funeral Director		5. Social Security Number 215-29-030	9 1XM 2_F	7. Age (In yrs. 4 (If Under 1 Year Months Days	If Under 24H Hours M	in	nth(MM/DD/YYYY)	9. Birthplace (State or Foreign MARW LAND
Maryland 28a-f show any d at once.	tor	Usual Residence of Decede 10a. State 10b. Cou MD 10e. Street and Number			, Town or Location	LK				10d. Inside City Limits 1 Yes 2 X No
the sa or	uneral Director	952 DALTO	12. Was Dec	edent Ever in U		10f. Zip Code 21 22 Decedent of Hisp	anic Origin? (Specify Yes or No		A . American Indian, Black,
ours after deat ntural", or ite	g. F	1 X Never Married 2 3 Widowed 4 15. Decedent's Education (Divorced If Yes, Give Yeal or Dates:	1 16a. Decedent	If Yes, specify Cuban, Mexican, Puerto Ricán, etc.) 1 Yes 2 No specify: eccedent's Usual Occupation (Give kind of work done			White, etc. Specify: WHITE 16b. Kind of Business/Industry		
5-0036 ed within 72 he tygiene. other than "m the Medical Es	Completed	Elementary/Secondary (0- 1 0 17. Father's Name (First, Mic		-4 or 5+)	during most of working life. DO NOT use ret LABORER				CONSTI	RUCTION
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 27 is marked other than umatic event, the Medica	9 Pe	MELVIN W .	GREENWA			Address (Street	PATR and Number or	ICIA A	A LOWI	State, Zip Code)
Baltimore, MD 2121. permit. Pages 1 and 2 should be fill Department of Health and Mental I important: If item 27 is marked injury or other traumatic event,	ı	PATRICIA GI 20a. Method of Disposition 1 Burial 2 X Crema		20b. om State	Place of Disposit crematory or other	ion (Name of ceme er place)	etery,	Date		City or Town, State
Baltimore, permit. Pages 1 an Department of Hea Important: If ther injury or other tra	1	4 Donation 5 Othe 21. Signature of Euros a Sen		BAY		REMATOR TEAST 01 EAST		30/11 VENUE, I	BALTIMO FUNERAL BALTO.,	DRE, MARYLAND HOME 10 21231
Physician /Medical Examiner		23a. Part I. Enter the disease failure. List only one ca Immediate Cause (Final dise or condition resulting in deat	use on each line. _{ase a.} Multiple Blu	nt Force Inj	uries	mode of dying, s	uch as cardiac	or respiratory arm	est, shock, or hear	t Approximate Interval Between Onset and Death
uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cai (Uisease or injury that initiate events resulting in death) La	ed C							
60, ate be executed hysician and c burial - transit	Medical	UNPENDED F FEMALE:	AMENDED	utcome of preg	nancy				23d. Date of de	Plivan
). Box 68760 the death certificate by the attending physiched for use as the bubbicity	1) Siciani	3b. Was decedent pregnant past 12 months?	in the 1 Live bit	rth ant at time of de	2 Feta	I death 3	Ectopic pregn	ancy	Month	Day Year
rds, P.O. requires that the been signed by the hould be detached by the beach by th	3	Part II. Other significant cor	iditions contributing to	death but not re	esulting in the un	derlying cause giv	en in Part I.	1 Yes	2 ✔ No 3	ute to the cause of death?
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atternompletely filled in by the funeral director, page 2 should be detached for a period of the funeral Control of the funeral director.	nanaldino s	5. Was case referred to med	lical I			26 Place of	f Death (Check	24a. Was a autop: perfor	sy prid med? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
In of Vital ling Physician: After this certification of the control of the cont		examiner? 1 ✓ Yes 2 No	Hospital:	patient 2	ER/Outpatient		thor -		Residence 6	Other: Scene
Division of tall or Attending Phers after death. al Director: After a led in by the funeral led in by the funeral artification:			28a. Date o (Month,) sending ending ending ending	f Injury Day,Year) 2011	28b. Time of Inju 2241 hrs		at Work? s 2 ✔ No		ow injury occurred struck by auto	
Division ospital or Attending tours after death. neral Director: After filled in by the function.		4 Homicide	ould not be	of Injury - At ho Major Road		factory, office buil	Iding, etc.	or Town, St	tate)	or Rural Route Number, City ice to Eas, Dundalk, MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		ne) 2 Medical E	Physician: To the best Examiner: On the basis of and manner sta	examination ar	ge, death occurre	n, in my opinion, d	leath occurred	d due to the cause at the time, date a	e(s) and manner as and place, and due	s stated. to the cause(s)
	2	9b. Signature and title of cer	THE	ND		29c. License r			29d. Date signed September 2	(Month, Day, Year) 6, 2011
- ✓		Name and address of pers Russell Alexander M	MD Assistant Me			. Baltimore S	treet, Baltin	nore, MD 212	223	
State Registra	e ³	1. Date filed (Month, Day Year SEP 2 9 201	ar) 32. Reg	istrar's Signatu	als			OCHE		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9 LACINTL (TAR 40 Medical 4c County of Death Facility Name (if not institution, give street and number) **Examiner** MORN NOSDE House AURel Social Security Number 5 78-6 4-705 6. Sex Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 T Min. Hours **Director** MAICA 28a-f show 10a. State 10b. County with the Maryland ms 23a or 28a-f sho must be notified at Director 10c. City, Town or Location 10d. Inside City Limits PRINCE GEORGE LAYREL 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7700 U. S. A. CHERRY 20707 Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced BLACK Year or Dates er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. GOVERNMENT ed other t event, th SECRETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental H item 27 is marked ot other traumatic ever ပ WESLEY MONI ROE MYRTLE STEWART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YMOONI THOMPSON other 1 BOWLE 3800 COURT MO 30721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or otl 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State ARDENT CREMATION 4 Donation 5 Other (Specify) SEPT. 28 2011 HANOVER, MO 21. Signature of un all Spice Licensee JOSEPH L. 22. Name and Address of Facility MAKZULLO FUNERAL CHAPEL CAMBY m00078 HARFORD ROAD. BALTIMORE MO 21214 part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between mediate Cause (Final Onset and Death Physician/ isease or condition resulting in death) lemen ng Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): burial-transit resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be P.O. Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy5 ☐ Other (specify) Month Pregnant at time of death Dav Vear 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed' 1 Yes Yes 2 3 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 A No Other: 1 Yes 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpa 4 ☐ Nursing Home 5 ☐ Residence 6 M Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending ours after death, eral Director: Aft filled in by the fun 2 Accident
3 Suicide Investigation 1 Tes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 70102

DHMH 17 Rev 7/2009

State Registrar 9200

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LARGO.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Physician/ 0 Medical 4a. Facility Name (if not institution, give stre **Examiner** and number 4b. City, Town, or Location of Death 4c. County of Death Transitions RSVI" cosville Security Number ear If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** If Undervi 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Min. Months Month, Day, Year) 919 Hours Country) **Director** 219-18-4801 Yrs Jan. Virgini Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4404 Fernhill Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Medical Examiner ō Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify Specify: Black "natural" 3 Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the <u>12th grade</u> Private Homes <u>Domestic Engineer</u> traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is many injury or othere. ည William Moses Mary Tones Jacquline L. Battle-Wynder/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Fairview Avenue Baltimore MD 21216 Method of Disposition 1 $\stackrel{\longleftarrow}{X}$ Burial 2 \square Cremation 3 \square Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 4 Donation 5 Other (Specify) 9-26-2011 timore National Cem. Baltimore, MD 22. Name and Address of Facility Chatman-liarris Funeral Home 21. Signature of Fune 5240 Reisterstown Road Baltimore, MD 21215 23a. Part 1. Enter the d ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ∦ Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and I-trans that initiated events resulting in death) Last physician are the bunal-t Due to (or as a consequence of) Physician/Medical Obivision of Vital Records, P.O. Box 68760 attending ph for use as the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day cate has been signed by the page 2 should be detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 □ Probably 4 □ Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npleted filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 31059 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1815 PM 2011 Ven Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL TIMORE 8. Date of Birth (Mortth, Day last birthday If Under 1 Year If Under 24 Hrs. **Funeral** g. Birthplace (State or Foreign 1 M 2 F Days Min. Months Hours Country) Director 28a-f show 10a State 10b. County with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 6 10e. Street and Numbe 10g. Citizen of What Country? 23a items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or amy injury or other traumatic event, the Medical Examinance. 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retifed) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary altimore econday (0-12) College (44 or 5+) Sto Be 18. Mother's Name (First, Middle, Majden Surname) ဂ 9a. Informant's Nam /Relationship (Type, Print) (Mugueter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat uperal Service Licensee Home, P.A. MD 2121 3 uneval July to. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Enter the disease of complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SEASIS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and hed for use as the burial-transii Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day signed by the aid be detached for 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Should ceen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy perform rmed? 2 No within 24 hours after death.

To the Funeral Director: After this certificate Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ည 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28h Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M 2011 tombur on who completed cause of death (Item 23a) (Type Print) Baltmore, Maryland allow 100 l

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Date Month **Physician** Year arole HALL 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examine BALTIMORE BAUTIMORE +Rumaton CITY Corne If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2/2 F 021-28-9285 Yrs 75 Director MA Aug. 11, Usual Residence of Decedent 10a. State 10b. County "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside/City Limits traumatic event, the Medical Examinant rust be notified at Director 1 Yes 2 No N/A MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 Funeral 5625 McClean Boulevard USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 □Yes 2 No 2 Specify Specify: Black 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 2 Years Own Home 12 should be filed wi h and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marion Roberts Walter Mack 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heatth ar Important: If item 27 is any injury or other trauonce. 128 Stephanie Dr. Franklinville, NJ. 08322 Leslie Bowden - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 9/30/2011 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, Maryland 21:206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician ardio polmonary disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner electronte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) dehydrution Due to (or as a consequence of) Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Vear Day 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u></u> deasitus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2No Hospital 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760. Records, Division of Vital

he law requires that the death certificate be executed physician and the burial-trans attending p seen signed by the should be detached to cale has this certificale

filed within 72 hours after death with the Maryland

Pages

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

D. 0

State Registrar

51 -

29c. License number 31926

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 9/27/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMAN MO 21229

31. Date filed (Month, Day,

29b. Signature and title of certifier

29a Certifier (Check only one)

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1730 P **Physician** Dember 25 2011 Hartman ance /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Johns Hopkins Bayview Medical Center 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, **Funeral** Days 1 XM 2 □ F February 27,1963 Maryland 218-90-2745 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Dundalk Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner misst handone. USA 21222 11 Flagship Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 XNo 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Central Wire Steel Worker 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Geraldine Bivens Kenneth F. Hartman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 Flagship Road, Dundalk, Maryland 21222 wife Brenda Hartman 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) September 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Dundalk, Maryland Sacred Heart Of Jesus Cem. 30, 2011 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 21. Sign were of uneral Service Mon76 7110 Sollers Point Road, Dundalk, MD. 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme rate Cause (Final disease or condition resulting in death) Respiratory 12 hrs failure Physician /Medical Due to or as a consequence of) 4 months **Examiner** Netastaho 1479 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events and Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 🗌 No Yes 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Bacterenia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 🗆 No 2 🔀 No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28d. Describe how injury occurred 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After 1 Natural 5 Pending investigation 1 Yes 2 No M s after death.

Director: Aft
d in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and fittle of certifier seplember 25 201 038176 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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a 31. Date filed (Mentil) Bay, Year,

2 9 2011

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** \$eptember 19 8:25 2011 Jeanne Marie Huneke /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 12540 Ulrich Ave. Baltimore Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Min. 212-70-1888 Months Days Hours 1 M 2 X F 09/21/1956 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Model Examinat must be notified at once. Y Yes 2 No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21220 12540 Ulrich Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) environment 12 6 environmental inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Inez Schreieck Harry Raymond Huneke ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12540 Ulrich Avenue; Baltimore, MD 21220 19a. Informant's Name/Relationship (Type. Print) Ethel Huneke - mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 21. Sign thre of Laneral Service Licenses 22. Name and Address of Facility State Anatomy Board Mirector 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate C use (Final disease or conditions) 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval Between Onset and Death NON SHALL CELL LUNG TRAP **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed Exam burial-tran and Due to (or as a consequence of) P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ∃Yes 2□No 9 Unknown signed by t The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 No this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

e Hospital or Attending Physician; '24 hours after death.
e Funeral Director: After this certifica letely filled in by the funeral director, p To the Hosp within 24 ho To the Fune completely fi

PHYSECIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

+ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00058475 SEPTEMBOR 22,2011

29d. Date signed (Month, Day, Year)

and manner stated

ally PHICADELPHEA ROAD BACTIMERS MD 2/23+ PHILIPNIAT

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certific

11-07210 George Hicks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day September 25, 2011 Medical Examiner 1205 hrs George Hicks, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Director Country) Maryland 1 X M 2 F 214-82-2993 Yrs 04/15/1964 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be political at ance Anne Arundel Director Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country 116 Greenway Village Place 21061 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specity Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify Specify: Black <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Landscaper Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Hicks, Sr. Helen Louise Spriggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Traciev Hicks / Daughter</u> <u>ll6 Greenway Village Place, </u> Glen Burnie, MD 21061 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 4 X Donation 5 Other Specify. 09/29/2011 Hanover, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a Intracerebral Hemorrhage Immediate Cause (Final disease <u> E</u>xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician/Medical \mathbf{x} AMENDED 1,23a,27, per me,g920 10-28-11 sm X UNPENDED ted by the attending physician detached for use as the burial Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No Division of Vital 25. Was case referred to medical 26 Place of Death (Check only one) B examiner? Hospital: 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: To the Hospital or Attenuary within 24 hours after death.

To the Funeral Director: A 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 26, 2011 30. Name and address of person who completed cause of death (Item 23a) 00 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Russell Alexander MD

DHMH 17 Rev 1/2001

Registrar

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32. Registrar's Signature

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			For State	State of Mary				Mental Hy	giene			
	_		Registrar 1. Decedent's Name (First, Middle, Last	9	Cer	tificate of	Death	2. Date of De	Reg. No.2	+ + -	31064	
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	Medic Examin		4a. Facility Name (if not institution, give s			4b. City, Town, o	or Location of Deat		4c. County		1 0.55am	
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100	Funeral		Social Security Number 6. Se	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			Birthplace (State or Foreign Country)			
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-	a or 2 be no		10e. Street and Number			10f. Zip Code 10g. Cit					ntry?	
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ב ב	rage ment ant; It ury or		1 ♣ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	L.		Cemeter Cemeter	· '	.4, 201	l Balt	o. M	id	
Baltimore,	permit. Page 13 Department of P Important; If its any injury or ot once.		21. Signatura of Funeral Service Lin nse	ee	22	Name and Addre	ess of Facility	ICCS FII	MEDAT.	HOME		
						<u>1412 E.</u>		JGGS FU ON ST.		MD		
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3	been signed by the attending physician and should be detached for use as the burial-transit	adic	•	d								
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DIVISION OF	fter de irecto n by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp		eet, factory, office		28f. Location (S City or Tov	Street and Numb	er or Rura	Route Number,	
DIVISION OT VITAL RECORDS, P.O. BOX 68/60	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		00-0-45	T the best of section								
H	E Fun	Medical	(Check 2 Medical Examin	ician: To the best of my ki ier: On the basis of examin e Practitioner: To the best	ation and/or invest	igation, in my opini	ion, death occurred	at the time, date a	and place, and du	ue to the ca	use(s) and manner state	
To th	within To the	2	29b. Signature and title of certifier	Traduction to the bes	to my knowledge,	29c. Licens		Jiaco, and ado to	29d. Date signe			
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			30. Name and address of person who co		(Item 23a) (Type, P	rint)			11	t ·		
			JACKIE JONES, CE		LANEY VA		TIMONI	UM, MD 2	1093		-	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8 Medical Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death
Baltim Examiner 4c. County of Death 8. Date of Birth (Month Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Months **Director** Yrs Mary 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) U.S. 14. Race - American Indian, Black, White, etc. 1 Dever Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🗹 No 3 Widowed 4 Divorced Completed a 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျ Print Dughter 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Method of Disposition Place of Disposition (Name of cemetery, crematory or other). 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MO Signate Funeral Service Licensee Home, Pa 53 Bal MO 23a. Part 7. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset an Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the burial-transi Cause (Disease or linjury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? cate has been signed by the atterpage 2 should be detached for Dav Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 **N**O Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autons death? hin 24 hours after death.

the Funeral Director. After this certificate Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 **X**No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 No Accident Investigation 6 Could not be ☐ Accider☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 26 2011 eath (Item 23a) (Type, Print) Charles Street, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5 per fb 2919 9-29-11 sm State of Maryland Department of Health and Mental Hygiene For State Registrar 31066 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 3:50 PM 201 John son Medical Facility Name (if not institution, give street and number, City, Town, or Location of Death 4c. County of Death Examiner LtimoRe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Hours Min Director Yrs. Usual Residence of D permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No timor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever i U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) Veteran's OO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mothe r's Name (First, Middle, Maiden မ Sister) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta , Zip Code, 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ered Home, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, ician Acute day disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Duri to for as a consequence off if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No To the Hospital or Attending Physician: The law requires that the death Year Month Day 1 Yes 2 L 9 Unknown signed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Hepatitis Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 횬 1 Yes 2 No 1 Anpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 \square Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) MD. PhD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Carleza Clayteen Johnson 2011 10:40 p^M Sept Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** Days Hours 578-44-9507 **Director** 1 M 2 M F Aparil 2, 1934 77 Maryland 3a or 28a-f show t be notified at 10d. Inside City Limits 10a, State 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ral", or items 23a Examiner must b USA 21215 5536 Nome Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Yes Give "natural". Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meany injury or other traumatic event, the Meany College (1-4 or 5+) Elementary/Secondary (0-12) Claims Investigator Social Security Admin. 3 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hilda Kemp Joshua Gregg, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 S. Fountain Green Road Bel Air, MD. 21015 Gregg Johnson - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) **I** Burial 2 ☐ Cremation 3 ☐ Removal from State 10/3/2011 Maryland Nat'l Mam. Park Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 23a. Part of Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final √Pnysician/ disease or condition resulting in death) Medical to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year 5 Other (specify) detached 9 Unknown g Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 ☐ Yes 2 25, Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 2 KNO 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Manner of De Th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury Certificate: work? injury 5 Pending 2 🗌 No Investigation after death Director: in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Registrar DHMH 17 Rev 06-2011

State

only one 29b. Sign

31. Date filed (Month, Day, Year

and title of certifier

SFP 29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Antoine James State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day September 21, 2011 0652 hrs Medical Examiner Robert Antoine James 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death n/a Johns Hopkins Hospital Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Hours Director 09/08/1981 Country) MD 30 213-98-5315 1 XM 2 F Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No Baltimore n/a hours after death with the Maryland rector 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21213 3419 Ravenwood Avenue USA ā 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 2 Vac 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify: Black ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene.

nut: If item 27 is marked other than ", in other traumatic event, the Medical E. Car Wholesaler Automobile Sales timore, MD 21215-0036 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hope Henson Robert Clifton James 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3419 Ravenwood Ave Baltimore, MD 21213 Hope Henson- Mother 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date Burial 2 Cremation 3 Removal from State crematory or other place Loudon Park Cemetery 9.28.2011 Baltimore, MD Donation 5 Other Specify: ignature of cuneral Service Liberates ^{22. Name and Address of Facility} **John L. Williams Funeral Directors,**4517 Park Heights Ave Baltimore, MD 21215 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and ailure. List only one cause on each line (Medical Death a. Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease of injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical physician the burial -UNPENDED AMENDED Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b, Were autopsy findings available

The law requires that the death certificate be executed Records. certificate this After

Be Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

25. Was case referred to medical

29b. Signature and title of certifie

Patricia Aronica-Pollak MD.

5 Pending

Investigation

30. Name and address of person who completed cause of death (Item 23a)

OCME

Could not be

1 Yes

27. Manner of Death

1 Natural

2 Accident

4 🗹 Homicide

Suicide

To the Hospital or Attending Physician: Division of Vital

State Registrar

Medical

Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury

Sep 20, 2011

and manner stated

(Specify) Local Street

28b Time of Injury

1625 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 📈 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

prior to completion of cause of

2 No

death?

28f. Location (Street and Number or Rural Route Number, City

September 22, 2011

29d. Date signed (Month, Day, Year)

or Town, State) 800 Block of E. 34th Street, Baltimore, MD

1 🗸 Yes

autopsy

Other Nursing Home 5 Residence 6 Other

Subject shot

26.Place of Death (Check only one)

28c. Injury at Work?

29c. License number

OCME

1 Yes 2 ✔ No

performed'

✔ Yes 2 No

28d. Describe how injury occurred

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1,26630 Per PHY G919 9/29/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month O Physician/ **∓** Violet JiJi 9:28 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MAYS CHAPEL RIDGE LUTHERVILLE TIMONIUM BALTIMORE 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Months Davs Hours 04/12/1927 Director 212-36-5978 84 IRAQ Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No BALTIMORE LUTHERVILLE TIMONIUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12261 ROUNDWOOD ROAD 21093 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PHYSICIAN MEDICAL marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HARON DARWISH SIMHA SAYEGH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD HOFFMAN/PERSONAL REP 1104 KENILWORTH DRIVE, SUITE 300, TOWSON, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PK. 09/26/2011 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Dunito (ar as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death Month Day Year Unknown 9 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ I or Attending Physician: The law requires a after death.

Director: After this certificate has been sigr Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes Be 25. Was case referred to medical Assisted 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Living 1 🔲 Yes ᅆ 1 Inpatient 2 ER/Outpatient 3 IDOA 6 28a. Date of injury (Month, Day, Year) 27. Manner of Dealr 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifie 🗖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fitle of certifier Sugardres of PMeltzerolel TexasdeStation Court, Suite 210 Lutherville Timonium, Md 21093 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

State

SEP 2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 2 20 Alma Ruth Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 5617 Plymouth Rd. 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. (Month, Day, Hours Days 930 1 □ M 2 🔀 F 81 220-24-2668 Director Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10b County 10c. City. Town or Location Director 1 Yes 2 No N/ABaltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 21213 .S.A. 1401 Lakewood St. Apt 108 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3

✓ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) unk College (1-4 or 5+) Liquor Store Cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jack Johnson Alma unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD21217 3 Balto Sheila Byrd(daughter) Druid Ave Apt 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/03/11 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) ²josephdorn i Brown Jr. 2140 N. Fulton Ave., 21. Signature of Funeral Service Licensee Funeral Home Baltimore, MD PA 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ned by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death certificate has been signed by the a rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ winknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? Yes 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medica examiner? Other: 4 Nursing Home 2 No 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပု After this (27. anne Death 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death. Funeral Director: After the Certificate: (Month, Day, Year) 5 Pending 1 Yes 2 No M Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State SEP 2 9 2011

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2011 Physician/ 1:55p Delores E. Jackson Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner N/ABaltimore Future Care 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 0890877929 Maryland 1 □ M 2 🔀 F 82 217-24-2460 **Director** Usual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 XYes 2 No Baltimore MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21218 U.S.A. 1701 Eutaw Place Apt 807 14. Race - American Indian, 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 X Married ☐ Yes 2 ☐No ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Key Circle Health Care Provider 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic eveni 17. Father's Name (First, Middle, Last) Olivia Harriette Walter Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1925 Eutaw Place, Baltimore, MD 21218 Delores Emmons(daughter) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1
Burial 2
remation 3 Removal from State 291 on-site Crematory 69 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses For Brown Jr. Funeral Home PA retich MD 21217 2140 N. Fulton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical death certificate be P.O. Box 68760 ending p IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Į, Pregnant at time of death 1 ☐ Yes 2 № 9 ☐ Unknown been signed by the should be detached or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Records, 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of has page 2 s 1 ☐ Yes 2 ☐ No this certificate After this certification Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury_at Certificate: Natural Accident Suicide work?
1 Yes 5 Pending 2 🗌 No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation in my animals. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4006426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 26, 2011 Physician/ 6:50 P M Nancy Lee Kirby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Dove House 8. Date of Birth (Month, Day, Year, . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Days Hours 213-42-3926 Director 68 1 □ M 2 🕱 F Sept 23, 1943 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director r 28a-f sl notified 1 Yes 2 X No MD Carroll Westminster ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 21157 USA 506 Ann Drive ral", or items ? I Examiner mus death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2X Married þ permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) the Seamstress <u>Clothing Manufacturer</u> 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ of Health and Menta fitem 27 is marked rother traumatic e William David Ruppert Frances Marie Stem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Ann Drive Westminster, MD 21157 William Kirby/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o = 10 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Important: It any injury or Final Journey Crematory 09/28/11 Woodbine, MD 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the duath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of: the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Other (specify) Pregnant at time of death 9 Unknown 1 ☐ Yes ≥ □ signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 🗌 No 4 Unknown 1 Yes 3 Probably is certificate has been sidirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred atural 5 Pendina injury Accident Investigation 24 hours after death Funeral Director: filled in by the 6 🗌 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check within 2 To the P only on 29b. Signatu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print State 2 9

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	036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	1 X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Vec Gi	2 🕅 No ve	1			Specify:		can, etc.)			ck, White, Whi		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 26, 20118:59 A. M Gregory Joseph Karwacki Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Days Hours Min Oct. 22 Year 1952 Maryland 58 **Director** 217-60-1979 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 XNo Abingdon Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21009 3721 Sewell Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces? 1 Never Married 2 Married þ Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Trucking Company Diesel Mechanic is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Regina Rose Emala James Stanley Karwacki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3721 Sewell Road, Abingdon, Maryland 21009 Department of Health a Important. If item 27 is any injury or other tranonce. Sonja Karwacki / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Fullerton, Maryland 9/30/2011 4 ☐ Donation 5 ☐ Other (Specify) Joseph Cemetery McComas Funeral Home, P.A. on the re of Feral Service Licensee 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to for as a consequence of if any leading to immedicause. Enter Underlying burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical cate has been signed by the attending p page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Month 5 Other (specify) Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No or Attending Physician; 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident completed filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗔 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) DOO 36487 30. Name and agdress of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Dr Bel Air, MD 21014 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 31075 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 21:35 JAMES KERNEY SEPTEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MERCY HEALTH SERVICES If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral Country) Days Hours (Month, Day, Year, 1 🔀 M 2 🗆 F Director Yrs 64 219-40-0406 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 No Baltimore n/a MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21206 5419 Moores Run Drive USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 ZNo Specify: Specify Completed 3 Widowed 4 Divorced Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Longe Shoreman Supervisor llth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Sparks Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5419 Moores Run Drive Baltimore, Md 21206 Irene Kerney/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Parkwood CemeteryDct.5,2011 Baltimore, Md Func (Servic Lice) see 22. Name and Address of Facility GGS FUNERAL HOME MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ NON-SMALL CELL LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to or as a consequence of: Examir attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, ASPIRATION PNEUMONIA 1 Yes 2 No 3 Probably 4 Unknown Completed should ! 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Yes 2 death? 1 ☐ Yes 2 🔀 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 1 Yes 2 No XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Accider 5 Pending Accident Investigation filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 25582 M.D SEPTEMBER 24 2011

DHMH 17 Rev 7/2009

State

Registrar

DANTE SUFFREDINI, MERCY MEDICAL CENTER 301 ST. PAUL PLACE BALTIMORE MD 21202

32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) ^{Day} 26, Physician/ 2011 September 8:30 P M Judith Lee Lehmer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Crofton 8. Date of Birth (Month, Day, Year) 1938 Crofton Care & Rehab. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Pennsylvania Director 161-32-4852 72 1 □ M 2 🗶 F Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10b. County must be notified at Director 28a-f 1 Yes 2 No MD Anne Arundel Crofton 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number ral", or items 23a -Examiner must be Funeral 21114 USA 1726 Torrington Place death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 🏋 No Specify: Specify: White 3 Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health and Mental Hygiene, tem 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Food Service Dining Hall Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ethel Ross Eugene Heine and A 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1726 Torrington Place Crofton, MD 21114 Lucinda Godfrey/daughter 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cometery, crematory or other place)
Final Journey Crematory 09/30/11 1 Burial 2 XCremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses Sing Home Cremation Service P.O. Box 784 MO1251 Reverly L. Heckrotte, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to lor as a consequence of: cause. Enter Underlying Cause (Disease or injury the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physiciar To Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 X No 3 Ectopic pregnancy
5 Other (specify) Year Month Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe 1 be a 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 1 Yes 2 No 1 ☐ Yes 2 💹 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending injury Accident Investigation 124 hours after death Funeral Director: A letely filled in by the f 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

To the Fune

completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗍 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D58797 09/28/11 30. Name and address of person who completed chuse of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Subashri

31. Date filed (Month, Day, Year)

Reddy,

M.D.

32.

Defense Highway #E Crofton, MD 21114

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 27 2011 Physician/ Edward Gerard Langmead 12:37p Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** Towson Baltimore 746 Camberly Court B-8 237 PM 8. Date of Birth (Month, Day, Year) June 16 1950 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 61 **Director** 217-56-6271 MD Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director MD Baltimore Towson 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Edward Lauguead 09/27/2011 permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important If item 27 is marked other than "natural", or items 23a or amportant if item 27 is marked other than "natural", or items bas a my inlury or other traumatic event, the Medical Examiner must be a USA Funeral 21204 746 Camberly Court B-8 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 No If Yes, Give Black, White, etc 1982-1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: white 1988 Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) cosmetology College (1-4 or 5+) hairstylist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry William Langmead Mary T. Malatesta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6125 Oak Hill Dr., Sykesville, MD 21784 19a. Informant's Name/Relationship (Type, Print) Mary T. Curran (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 10-3-11 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Parge Harghet 3 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Artonoso Cardiol Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Exami Cause (Disease or iinjury the burial-transit n and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical The law requires that the death certificate be P,O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? iniury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of ca leted cause of death (Item 23a) (Type, Print) 101 State

Registrar

Page Not Found

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 27, 2011 Physician/ 4:00 A M Frederick Christian Laubach Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Bel Air 2911 Creswell Road 8. Date of Birth (Month, Day, Year) Aug. 21, 1927 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 1 XM 2 □ F Months Days Hours Director 216-20-3712 84 Usual Residence of Deceder ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 Yes 2 No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe Funeral 2911 Creswell Road 21015 USA permit, Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event than "natural", or items; Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status . Was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: White 3X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Construction Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie Margaret Wiegand David Henry Laubach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2909-A Creswell Road, Bel Air, Maryland 21015 David Laubach / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Zion U.M.C. Cem. 9-30-2011 Bel Air, Maryland 4 Donation 5 Other (Specify) 21. Signetial of Funeral Service Accepted 22. Name and Address of Facility McComas Funeral Home, 1317 Cokesbury Rd., A 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to lor as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 attending IF FEMALE for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death Ectopic pregnancy 3 in the past 12 months? 5 Other (specify) 2 🗌 No been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available 24a. Was an autopsy performed?
Yes 2 No Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director; After this certificate has b prior to completion of cause of death? Prostutic 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F only one 29b. Signature and title of certifier D0065827

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Registrar

DHMH 17 Rev 7/2009

ke Dr Belar MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 2

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Division of Vital Records, P.O. Box 66/60,	1	g D
To the Hospital or Attending Physician: The law requires that the death certificate be executed	Ph /I Ex	permi
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	ysic Vledi amí	Depa Imbo

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	-	For State Registrar	State of Maryland / De	epartment of H Certificate of L			giene Reg. No 2011	31080
Physiciar /Medica		1. Decedent's Name (First, Middle, Last) Cowan Edward Layn	e			2. Date of Dea Month Septemb	er 20 20 1	3. Time of Death 7:33 P M
Examine		4a. Facility Name (If not institution, give stre 1020 Western Chap	eet and number)	4b. City, Town, or Westmi	Location of Death		4c. County of Dea	
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 06/17	v. Year) Co	thplace (State or Foreign buntry) est Virginia
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with the Na a or 28a-	al Director	10e. Street and Number 1020 Western Chap	el Rd.	10f. Zip Code 21157			10g. Citizen of What Co USA	L puntry?
is a	by Ful	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Notorced	Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No 1943 If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 🕅 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Ye's or No Rican, etc.)		
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of Heal	Ì	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Place of D	Disposition (Name of crematory or other place		Date	20c. Location - City or	
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perm Depa Impo any i		21. Signature of Superal Service Ucensee ROTald S	de Director				Ltimore, MD	21201
Physician		23a. Part Enter the disease, or complicate shoot or heart failure. List only one of Immediate Cause (Final disease or condition	tions that caused the death. Do not cause on each line.	t enter the mode of dyin		or respiratory a	rrest, ambcdan	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of)		tuma	md o	cdon	
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of)	: (1				
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ficate be expression is the buria	edica	d.						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit manning of the funeral director.	Physician/Medical	IF FEMALE: 23c 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of d Month	elivery Day Year
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	ian: To the best of my knowledge, r: On the basis of examination and/and manner stated.	death occurred at the til or investigation, in my c	me, date and place opinion, death occur	, and due to the rred at the time	e cause(s) and manner , date and place, and d	as stated. ue to the cause(s)
To th To th Comp	Me	29b. Signature and title of certifier	againia MD	29c. Licens	e number 0 18 20	0	29d. Date signed (Mo.	
		30. Name and address of person who comp CHITRA (HEDY N	AGANNA 700	A poole a	d. WES	STMINS.	TER MI	21157
State Registra		31. Date filed.(<i>Month, Day, Year</i>) SEP 2 9 2011	32: Registrar's Signature	ale				/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST ተኝ,20 ቸኘ 2:45 рм TAKARA ALTHEIA LECKEY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Days Hours Months Min 6 0874972011 MARYLAND **Director** N/A Usual Residence of Decedent 28a-f shov 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No COCKEYSVILLE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 U.S.A. 609 K CRANBROOK ROAD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Şeconday (0-12) College (1-4 or 5+) N/A N/A N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of NATASHA MARS HAKIM LECKEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is: any injury or other the CRANBROOK RD., COCKEYSVILLE, MD 21030 NATASHA MARS/ MOTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 \square Burial 2 X Cremation 3 \square Removal from State 8/20/11 BAYVIEW CREMATORY BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funoral Service Licensee LILLY Addresz ÉTLER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac ir respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be phy 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death Month Year the a signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 2 No death? 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Other: မ 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work' 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be the 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Box 68760 P.O. Records, of Vital or Attending Physician: Division

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Af filled in by completed

State

DHMH 17 Rev 7/2009

Registrar

Medical

29a. Certifier

(Check only one

DOMINIQUE ALLEN, M.D. 6569 N. CHARLES ST., SUITE 501, BALTO., MD 21204 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0053109

29d. Date signed (Month, Day, Year)

21,2011

SEPT.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:45a _M Physician/ AUGUST Pag, 2019a1 LECKEY ALICE TAYLOR Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER 5. Social Security Numbe 8. Sex If Under 1 Year If Under 24 Hrs. 9 Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Hours 1 M 2 X 08718711 MARYLAND Vre Director N/AUsual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits must be notified at Director 28a-f 1 Yes 2 X No COCKEYSVILLE MD BALTIMORE 10f, Zip Code ō 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral U.S.A. 21030 CRANBROOK ROAD 609 death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 X No Black White etc ō 1 Never Married 2 Married ģ Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ XNo Specify: BLACK Specify: "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the N/AN/AN/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) lith and Mental F 27 is marked or r traumatic eve ပ NATASHA MARS LECKEY JAMAL HAKIM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CRANBROOK RD, COCKEYSVILLE, MD 21030 it of Health a: If item 27 i NATASHA MARS/ MOTHER 609 K Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State ò Department of Important: If any injury or once. BALTIMORE, MARYLAND BAYVIEW CREMATORY 8/20/11 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
TLLY & ZEIL
901 EASTERN ERVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on such line. Interval Between Immediate Cause (Final Onset and Death Phy i ian disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) -transit Exami and Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) st 12 months? 2 X No in the past 12 Month Day Year Pregnant at time of death 1 ☐ Yes ∠ 2 9 ☐ Unknown detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Tyes 2 No Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 2 🗶 No မ 1 Yes 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: XNatural 5 Pending injury 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

Division of Vital Records, To the Hospital or Attending within 24 hours a соmpleted

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOMINIOUE 6569 N. ALLEN, M.D. CHARLES ST., SUITE 501, BALTO, MD 21204

State Registrar

(Check

only one 29b. Signature a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D0053109

29d. Date signed (Month, Day, Year)

21,2011

SEPT.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:00P M 26 Sept 2011 Walker Franklin Martin. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2825 Salisbury Avenue Edgemere Baltimore Co. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Director 216-24-7407 1**X** M 2 □ F Yrs April 16,1929 Maryland Usual Residence of Decedent or 28a-f show 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2825 Salisbury Avenue 21219 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗙No Specify: 3 Widowed 4 Divorced Specify: White Completed WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 10 Years Foreman Steel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walker Franklin Martin, Sr. Sarah C. Byram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 so it of Health a: If item 27 i Mr. David Alan Martin (Son) 1922 Trout Farm Road Jarrettsville, MD Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept. 30, 201 permit. Page 1 and Department of I Important: If i any injury or o 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD Garrison Forest V.A. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dudalk Maryland 21222 21. Signature a Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter tradisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear the Lat only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) -415 cancer Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 2 No Hospital 1 Yes ၉ 4
Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Pospital or Attending Pi 124 hours after death. Funeral Director: After the letely filled in by the funera 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check Pedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 003695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9114 Philadelphia Rd. Suite 128 Althouse

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2011 3 1 0 8 4 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 26°. 2011 2:00 PM September Miller Veronica С. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 7314 Old Harford Road If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director 215-12-7556 Maryland 1 🗆 M 2 🗶 F 89 11-04-1921 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Examiner must be notified at Director N/A Baltimore 1 X Yes 2 No Maryland 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21234 USA 7314 01d Harford Road "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 X No Yes, Give Completed by 72 hours after 1 Yes 2 XNo Specify White Specify 3 Widowed 4 Divorced Year or Dates event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Maryland State and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Government **Supervisor** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Amerlia C. Bornschlegel Joseph W. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. David Engelman - Nephew 21 Ashbrook Court Aiken, South Carolina 29803 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 XBurial 2 Cremation 3 Removal from State Baltimore, Maryland 09-29-2011 Gardens of Faith Cemetery 5 Other (Specify) 4 Donation 5305 Harford Road 22. Name and Address of Facility 21. Signatur Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause Final Ph sician/ 100000 NUME disease or condition Medical resulting in death) **Examiner** Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine executed burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Year Day Pregnant at time of death
Unknown 1 Yes 2 No signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy page perform 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Dath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending iours after death.

neral Director: Aft
filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Division of Vital Records, P.O. Box 68760 within 24 hours a

Maryland 21215-0036

Baltimore,

State

12

Medical

29a. Certifier

only one) 29b. Signature and title of o

who completed cause of death (Item 23a) (Type, Print)

8109

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month

alkville

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 31085 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 12:05 AM Yvonne Joan Patricia Merritt 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Country) Maryland 1 M 2 F Months July 29, 212-60-5617 60 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 USA 3907 Woodlea Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 Never Married 2 Married þ 1 Yes, 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. College (1-4 or 5+) **5+** Elementary/Seconday (0-12) The Chimes Caregiver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked o Edward Henry Marcus Pearleen Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, 3907 Woodlea Avenue Baltimore, Maryland 21206 Samuel Merritt, Sr. - Husband Baltimore, 20b. Place of Disposition (Name of 20a. Methed of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 9/30/2011 Owings Mills, Maryland Carrison Forest Vet. Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses ullen 4210 Belair Road Baltimore, Maryland 21206 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CANCER CACHEXIA 1 disease or condition Medical resulting in death) Examiner CARCINOMA LEFT BREAST TASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 | Yes 2 No 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by MELLITUS, HYPERTENSION, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DYSUPIDEMIA, PERIPHERAL NEUROPATHY, 24a, Was an performed? PONTINE INFARCT 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DCA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗆 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier LES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601, LOCH RAVEN BLUD

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SAMEEP 31. Date filed (Month, Day, Year)

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ames McHale,		State of Maryland / Dep 1- For State Co Registrar Co	oartment of e <i>rtificate of</i>			2011 ag. No.	3108		
Physicia cal Exami	an/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 19, 2011							
)	lei	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death	Septembe	4c. County of Death	1424 hrs		
		Johns Hopkins Hospital	I - 4 b i do do d	Baltimore	le Date of Birt	th(MM/DD/YYYY) 9. Birti	onlace (State or		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday) Yrs	If Under 1 Year If Under 24Hrs. Months Days Hours Min. Min.	9/25/	Foreign			
any		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Locati	ion			10d. Inside City Limits		
*	١	·	per Dark	by Township			1 Yes 2 No		
eath with the Maryland items 23a or 28a-f sho ast be notified at once.	Director	10e, Street and Number		10f. Zip Code	10	Og. Citizen of What Coun	try?		
th the N 23a or notified		4514 Bond Ave.	Leave	19026		USA	and the Dist		
ath wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Y	as Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,		
P 5 E	by Fu	3 Widowed 4 Divorced of Dates:	Specify: U	hite					
hours a		15. Decedent's Education (Specify only highest grade completed)	16b. Kind of Business/Ir	ndustry					
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12	HVAC						
Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinling or other traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last) James J. McHale	Maiden Surname)						
2121 ald be f Mental marke	To Be	19a. Informant's Name/Relationship (Type, Print)	ber, City or Town, State,	Zip Code)					
MD d 2 shot lith and m 27 is numaric		James J. McHale	,Pa. 19026						
ore, of Heal If iten		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Pelaware County Crematory 9/21/11 Lansdon							
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		Name and Address of Facility	9/21/1	I Lansaou	ne, ra.		
Bal permi Depar Impo injur		21. Signature of Furier Convey Encourage	Da 40	vid J. Weber Fune 1 S. Chester Stre	eral Hon	mes P.A. Limore. Mary	land 21231		
Physician	(23a. Part I. Enter the disease, or complications that caused the dea failure. List only one cause on each line.	th. Do not enter the	he mode of dying, such as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and		
/Mndical Examiner		Immediate Cause (Final and a Han in or condition resulting in death) a. Han in Due to (or as a consequence	of):				Death		
		Sequentially list conditions, b							
	miner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	of):						
13: 5 8 /s	Exan	(Discess or injury that initiated events resulting in death) Last	of):						
O, e be executed ysician and burial - transit	edical	d. MENDED AMENDED 23a, 27,		er me,g920 10-7-1	1 sm				
760, cate be physici	/Med	IF FEMALE: 23c. If yes, outcome of pre	egnancy			23d. Date of delivery	5		
Sox 6876 leath certificate e attending phy for use as the b	iai	past 12 months? 4 Pregnant at time of	do ath	etal death 3	псу	Month D	ay Ye ar		
Boy ne death the att	Physi	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but no	A lain in abo	and all its accuse disease in Root I	230 Didto	bacco use contribute to t	he cause of death?		
i, P.O.	Ď	Part II. Other significant conditions continuously to death but no	t resulting its the t	underlying cause given in raici.		2 No 3 Prob			
ords, w require s been si should b	Completed				24a. Was a		opsy findings available		
Reco The law icate has	dmo					med? death?	s 2 No		
tal Rec	BeC	25. Was case referred to medical examiner? Hospital: 1 Innation 2	d and a second	26.Place of Death (Check of Double o		n			
of Ving Physical After this	<u>۲</u>	1 Yes 2 No 28a, Date of Injury	✓ ER/Outpatient 28b. Time of I			Residence 6 Other:			
ion c tending eath. tor: Af	ation	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No subject hanged self							
Divisi pital or At ours after d	ertifica	2 Accident Investigation 1d 9-19-11 1d 01:04 Dill 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Nor Town, State) 101 N. Potomac Could not be determined (Specify) residence Raltimore Md							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
To the Hos within 24 h To the Fur	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y								
	O.C.M.E. September 20, 2011								
ϕ	30. Name and address of person who completed cause of death (Item 23a)								
	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
St	ate	31. Dat me (Mant) Dat (a) 32. Registrar Sign	parket	•		Mr. M.C.			

11-06677	
Willie Morris	

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible. 20 | 3 | 0 8 8 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.							
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last) Willie Morris	2. Date of Dea Month Septemb	Day Year er 4, 2011	3. Time of Death 2310 hrs				
Contract Con		4a. Facility Name (if not institution, give street end number) 4b. City, Town, or Location of		4c. County of Dea	ath				
		513 East Cold Spring Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	r 24Hrs Is Data of B	irth(MM/DD/YYYY) 9. E	Birthplace (State or				
Funeral Director	1	Months Days Hours		For	eign CountrWirginia				
, as-	ŀ	217-20-3430 1 AM 2 F 92 Yrs. Usual Residence of Decedent	1007,	1010	7, 1181114				
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
Aaryland 28a-f show 1 at once.	ъ	MD Baltimore			1 X Yes 2 No				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked ather than "natural", ar items 23a ar 28a-f sho natic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 513 E. Coldspring Ln. 10f. Zip Code 21212		10g. Citizen of What Co USA	ountry?				
with the ms 23a be noti		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Marital Status 14. Never Married 2 Year and Forces? 15. Was Decedent of Hispanic Original Marital Status		o- 14. Race - Am White, etc.	erican Indian, Black,				
ter death	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, specify Cuban, Mexican, 1 Yes 2 No 1 Yes 2 No specify:	, 40,100 (1,104), 410,17	Specify: b]					
ours aff	g	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give k	kind of work doneun						
21215-0036 Id be filed within 72 hours after from the Figure of the filed within 72 hours after from "natural", event, the Medical Examiner event, the Medical Examine.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT	use retired)	A 17 C4	too1				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medical	E	unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother	s Name (First, Middle,	A.K. St Maiden Surname) U1					
215 be filed ntal Hy rked n	Be	dik							
21 hould I is mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num							
, MD and 2 sho ealth and cm 27 is	-	Donta James – great nephew 7611 Johnny Cake 20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Rd; Balti	20c. Location - City					
Baltimore, MD 2 permit Pages and 2 shoul Department of Health and N Important: If item 27 is unjury or other traumatic		1 Burial 2 Cremation 3 Removal from State crematory or other place)							
altin mit. P. portan ury or	1	4 Donation 5 X Other Specify: in State 21. Sina of Funeral Pervice Licentary Director 22. Name and Address of Facility	State An	atomy Boar	d				
	- 3	655 W. Baltim							
Physician /Medical		23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cafailure. List only one cause on each line.	ardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and Death				
xaminer	1	Immediate Case (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Dodan				
' - V'		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	Examiner	Clisease or injury that initiated			2				
nted d ansit		events resulting in death) Last Due to (or as a consequence of): d.							
8760, ificate be executed g physician and is the burial - transit	Physician/Medical	UNPENDED AMENDED							
8760, ifficate be ng physic as the bur	Z/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	pregnancy	23d. Date of deliv Month	very Day Year				
30x 687 death certific e attending F for use as th	icial	past 12 months? 4 Pregnant at time of death 5 Other (Specify)							
P.O. Box 6(s that the death cert	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I 23e. Did	tobacco use contribute	to the cause of death?				
		Chronic Obstructive Pulmonary Disease			Probably 4 🗹 Unknown				
rds, requir heen si	etec		24a. Wa		autopsy findings available to completion of cause of				
Ceco	Completed by		per	formed? death					
tal Recision: The certificate	BeC	25. Was case referred to medical examiner?			Victoria de la constanta de la				
Physic rat this a	P	1 ✓ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA		Residence 6 O	ther: Scene				
on of nding P. th.	ioi	27. Manner of Death 28a. Date of Injury (Month, Dey,Year) 28b. Time of Injury 28c. Injury at Work 1 Ves 2		e now injury occurred					
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number,								
Opical or posterior at the posterior or post	3 Suicide 6 Could not be determined (Specify) or Town, State)								
the H hin 24 the F apletel	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and playone) Wedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred.	ace, and due to the ca ccurred at the time, da	use(s) and manner as t te and place, and due t	stated. o the cause(s)				
T wiji	ğ	29b Signature and title of certifier 29c. License number		29d. Date signed ((Month, Day, Year)				
		(A) (O.C.M.E.		September 6,	2011				
_		30 Name and ddress of person who completed se of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street,	Baltimore, MD 2	21223					
	tate								
Regis				UGBE					
DUBALL 47 D 4/0	004	ODIOMAL		COME	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene O. 1. 1

		•	For State Registrar	State of Mary		artment of H tificate of D			eg. No.	31089
ı	Physicia		Decedent's Name (First, Middle, Las		MA	DVC		2. Date of Deatl Month	h Day 75 20	3. Time of Death 10:15 A M
	Medic Examin		PAULA R 4a. Facility Name (if not institution, give	EEVA street and number)	MA	RKS 4b, City, Town, or	Location of Death	SET LEMD	4c. County of E	
أمسه) Ladimii		CORSICA HILLS	NURSING HOME	Ξ	CENTE	ERVILLE			ANNES
	Funeral Director		5. Social Security Number 6. Security Number 1	7. Age (In	yrs. last birthday) 31 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 10/31/1		Birthplace (State or Foreign Country) VA
	nd ihow at	۱,	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Aaryla 8a-f s tified	Director	MD QUEEN A	NNES	CENTER	VILLE				1 🗆 Yes 2 🔀 No
	the Na or 2		10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	t Country?
	h with	Funeral	205 ARMSTRONG S			216			USA	
	r deat or iten niner r	y Fu	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 Yes 24 No	in U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ed by	3 Widowed 4 XDivorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🛣 No	Specify:		Specify:	WHITE
2-0	2 hour "natu dical	plet	15. Decedent's Ed (Specify only highest gra		16a. Deced	lent's Usual Occupa	ation Juring most of worki	ina	16b. Kind of Busine	ess Industry
7	thin 7%	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. De	O NOT use retired) LES		9	RET.	Δ TT.
Maryland 21215-0036	filed wil al Hygie d other event, th	Be (17. Father's Name (First, Middle, Last)) JA	1113	18. Mother's Name	e (First, Middle, N		
Jan	l be fil lental rked tic ev	일	FRANK	ROSENO	GARTEN		SOPHIE	,, ,	,	LEITMAN
ary	2 should be th and Men ?7 is marke traumatic		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	l Route Number,	City or Town, State	, Zip Code)
			ROBIN DONOHUE/DA				DOWNS, E			
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	20b. Place of Dispo cemetery, cren BALTIMOR	natory or other plac	e) i	8/2011	20c. Location - City BALTIM	y or Town, State ORE, MD
Balti	permit. Departm Imports any inju once.		21. Juna lire of Funeral Service Live	11100					ON & BRO	
	_	Н	23a. Part 1. Enter the disease, or companies shock, or heart failure. List only o	olications that caused the	e death. Do not ente	er the mode of dying	g, such as cardiac o	or respiratory arre	st,	Approximate
	Physician/ Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a Adu	It taill	ure to	thrive	/		Interval Between Onset and Death
and of	Examiner		Survey Turi Ober 1 Wastista Ais USA							news
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Oue to (or as a co	ons (uence of).	11-11-11		77.000		
	cate be executed physician and the burial-transit	xar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Hypens	Dys to for as a consequence of:					gers
0	be exi	edical	L.	Atheres	clorass					uears
3760	ficate g phys	Jedi		d. 7 1/10/2	1.00-70					
Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ☑ No 9 ☐ Unknown	23c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date o Month	f delivery Day Year
O. O.	that th	by Pr	Part II. Other significant conditions co	ontributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did tok	pacco use contribu	te to the cause of death?
S,	quires en sign uld be	edb						1 🗆 Ye	es 2 🗆 No 3 🛭	Probably 4 Unknown
COL	aw rec las bee	Completed						24a. Was ar	sy prio	e autopsy findings available r to completion of cause of
Re	: The cate h							1 Ves		tn? Yes 2 No
Ita	sician certif irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	0 □ ED/0 +#	Othe	ace of Death (Checker:		о П он <i>"</i> "	
<u></u>	g Phy er this eral d	te: To	27. Manner of Death	28a. Date of injury (Month, Day, Ye	2 ER/Outpatier	28c. Injury	/ at		ence 6 Other (Sow injury occurred	Бреспу)
on	endin eath. or: Aft	ficat	Natural 5 Pending 2 Accident Investigation		ear) injury	M 1 □	Yes 2 No			
Division of Vital	al or Att s after de l Directe d in by t	Certificate:	3 Sulcide 6 Could not b 4 Homicide determined	28e. Place of Injury - building, etc. (S		eet, factory, office		28f. Location (St. City or Town		r Rural Route Number,
	e Hospita 24 hour e Funera leted fille	ledical	(Check 2 Medical Exami	sician: To the best of my ner: On the basis of exam se Practioner: To the bes	ination and/or invest	tigation, in my opinio	on, death occurred at	t the time, date an	d place, and due to	the cause(s) and manner stated.
	To the within to comp	N	29b. Signature and title of certifier	Vanh	M	29c. License			9d. Date signed (M	
			30. Name and address of person who of	ompleted cause of death	(Item 23a) (Type, F	Print)	e FActor	n Mi	21/100	,
	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's	ignature	1	y Layo	101)	1001	
	Registra		SEP 2 9 2011	Charge &	. Marie					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month mbe Physician/ 0459AM Barbara Francis Moore Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 XF Days Hours 0972777951 Maryland 216-54-2249 61 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director MD N/A Baltimore 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a Funeral 21201 must 1100 Bolton St. Apt 404 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Examiner 0 þ 1 Never Married 2 X Married Yes 2 MVc Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 F Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event ***. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 3 Oles Envelope Co. Laborer years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Purnell Oden Helen Gary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 N. Chester St., Baltimore, MD 21231 Kenyone Moore(daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 09/28/11 Baltimore, MD アの智密的Madffss of Birrown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore,MD 21217 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 901disease or condition Medical resulting in death) Examiner of sweet Sequentially list conditions, Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and -transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death 2 No ed by the a 9 Unknown g Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 : within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA မ 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) To the Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of gertifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2011 2. Registrar's Sign

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Pallan Physician/ 20 l Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Good Samaritan Nursing Center . Social Security Number 6. Sex 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under **Funeral** Days Hours 03-21-1926 121-16-1883 85 MA Director Yrs show 10d Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c, City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified Maryland N/A Baltimore 1 Yes 2 No 10g. Citizen of What Count USA 10e. Street and Number 10f. Zip Code 21206 Funeral 3904 Mayberry Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify: 3 X Widowed 4 Divorced White WII Year or Dates 15. Decedent's Education 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. is marked other tha City Government Forestry 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert A. Pallanck Blanche M. Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 5813 N. Hazelwood Avenue Baltimore, MD 21206 Steve A. Pallanck - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 \nearrow Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) 09-28-2011 Owings Mills, Maryland Garrison Forest Veteran er I Se vo Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. En/ r th disease, o'c implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List of young cause on each line. Approximate Interval Betweer Immediate Cause Final Onset and Death Physician/ disease or co dit in resulting in dea) Medical Examiner Sequentially list conditions Examiner Due to (or as a consequenif any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed wer that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 1 Tes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital 1 🗌 Yes 읻 ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of injury (Month, Day, Year) Manner of Deatl 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral Completely filled Medical Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 20 0 plember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NUE State

DHMH 17 Rev 06-2011

Registrar

11-07028
Cedric Perry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Cedric Perry	State of Maryland 1-For State Registrar	I / Department of Heal Certificate of Deal		ygiene Reg.	2011	3109	
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)			2. Date of Death Month September		3. Time of Death 1919 hrs	
	4a. Facility Name (if not institution, give street and number 3800 W. Belvedere Ave # 416	r) 4b. City, Baltir	Town, or Location of Deatl		4c. County of Death		
Funeral Director	5. Social Security Number 6. Sex 7. A 113-52-8450 1 M 2 F 52	Month	er 1 Year If Under 24Hrs as Days Hours Mir	. 1	(MM/DD/YYYY) 9. Birtl Foreign		
d Maw any Ke	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits 1 X Yes 2 No	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ar items 23a or 28a-f shuw injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Maryland N/A 10e. Street and Number 3800 W. Belvedere Ave. #416 11. Marital Status 12. Was Deceder	Baltimore 10f. Zig	1215		. Citizen of What Coun		
s after death with ral", ur items 23	1 Never Married 2 Married 1 Yes 2 3 Widowed 4 Divorced or Pales:	? If Yes, speci 2 No 1 Yes 2	ent of Hispanic Origin? (S fy Cuban, Mexican, Puerto X No s <i>pecify:</i>	Rican, etc.)	14. Race - Americ White, etc. Specify: Bla	ck	
5-0036 ed within 72 hours lygiene "natur ther than "natur the Medical Exam Completed	15. Decedent's Education (Specify only highest grade co Elementary/Secondary (0-12) College (1-4 or 12th grade	during most of wo	Dccupation (Give kind of king life. DO NOT use ret	ired)	6b. Kind of Business/Ir Private Co		
21215-0036 ould be filed within 7 d Mental Hygiene. s marked uther than tite event, the Medica To Be Comple	12th grade 17. Father's Name (First, Middle, Last) Floyd Perry 19a. Informant's Name/Relationship (Type, Print)		18.Mother's Name Marie Br (Street and Number or I	e (First, Middle, Mai Tyant	iden Surname)		
re, MD 3 s 1 and 2 shouf Health and 1 If item 27 is 1 ier traumatic	Ella Parks/ Aunt 20a Method of Disposition 1 Burial 2 X Cremation 3 Removal from S	114 Ryerso 20b. Place of Disposition (Nar	on St. Brook ne of cemetery,	lyn, NY 1			
Baltimore, permit. Pages 1 ar Department of Hee Important: If the injury or other tr	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Greenmount Cer 22. Name and					
Physician /Medical Examiner			-			Approximate Interval Between Onset and Death	
*	or condition resulting in death) Due to (or as a consistence of the conditions, if any, leading to immediate Due to (or as a consistence of the conditions, if any, leading to immediate						
ecuted and transit							
be ex sician urial -	UNPENDED AMENDED IF FEMALE: 23c. If yes, outco	me of pregnancy			23d. Date of delivery		
Division of Vital Records, P.O. Box 68760, To the Hospital ar Attending Physician: The law requires that the death certificate be evithin 24 hours after death. To the Funcaral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burial edical Certification: To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months?	2 Fetal death t time of death 5 Other (Spec	3 Ectopic pregna	incy	Month Da	ay Year	
s, P.O. I unres that the n signed by the detache	Part II. Other significant conditions contributing to deat	th but not resulting in the underlying	cause given in Part I.	1 Yes	cco use contribute to the	ibly 4 🗸 Unknown	
Division of Vital Records, tal mr Attending Physician: The law requires as after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed				24a. Was an autopsy performe	prior to co	opsy findings available mpletion of cause of	
f Vital Physician: or this certi ral director To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatio		OA Other Nursin		sidence 6 🗸 Other:	Scene	
ion of trending Pl death. ctor: After y the funera	27. Manner of Death 1 ✓ Natural 5 Pending 2 Accident Investigation	ury 28b. Time of Injury 2 (ear)	8c. Injury at Work? 1 Yes 2 No	28d. Describe how	v injury occurred		
Division o fospital ar Attending hours after death, uneral Director: Afte y filled in by the fune I Certification:	4 Homicide determined (Specify) 29a. Certifier A Continue Devicing Table has for	njury - At home, farm, street, factory,		or Town, State			
Tn the Hos within 24 h within 24 h completely completely ledical ((Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or investigation, in my	opinion, death occurred a	t the time, date and	d place, and due to the	cause(s)	
1 (29b. Signature and title of certifier		O.C.M.E.		9d. Date signed <i>(Mont</i> September 24, 20		
4	 Name and address of person who completed cause of c Ling Li, MD Assistant Medical Examine 		t, Baltimore, MD 21	223			
State Registrar	31. Date filed (Month, Day, Year) 32. Rygistra	r's Signature & Saule					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ PARK BOBBIE MARIE SEPT 19 2011 10:50a™ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY 6. Sex If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Months Days June 16 Country) 1 □_XM 2 □ F 1959 Director 222 - 54 - 134Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4319 Hunt Place 20002 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental P 2 Robert Alexander Park

19a. Informant's Name/Relationship (Type, Print) PROGRAM Margaret Mickel other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Q ST NE WASHINGTON, D.C. 20002 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau. PATHWAYS TO HOUSING 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 \square Burial 2 \overline{X} Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9 - 23 - 11Beltsville, Md. Chesapeake Crem. of Funeral Service Licenses 22. Name and Address of Facility Capitol Mortuary, 20002 NE Maryland Ave.. Part 1. Enter the disease shock, or heart failure. , or complications that caused the delist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a co or Attending Physician: The law requires that the death certificate be executed that initiated events and Due to (or as a consequence of resulting in death) Last physician the burial Physician/Medical P.O. Box 68760 attending philor use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛱 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Pregnant at time of death been signed by the should be detached g Unknow Unknown 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy this certificate 1 Yes 2 No Yes 2 X No Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 Hospital: Other: 1 🗌 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate 1 Natural 2 Ccident 5 Pending work? 1 Tes 2 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

James

Demetrois

DHMH 17 Rev 7/2009

3001 Hospital

20785

Md

Cheverly,

Drive

person who completed cause of death (Item 23a) (Type, Print)

Catevenis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 20, 2011 Matthew Stanley Ouay 1200 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Hebrew Home . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours May 9, Day 1942 Washington, D.C. **Director** 048-32-8734 69 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 402 W. Montgomery Avenue 20850 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1965–68 1 ☐ Yes 2X No Specify. "natural", Specify: 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Executive Reinsurance Company injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be filed h and Mental H 7 is marked oth Richard Roberts Quay, Jr. Marjorie Brownlee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 3032 Rice Blvd. Houston, TX 77005 Richard D. Quay/brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date remetery, crematory or other place)
Final Journey Crematory 09/30/11 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licenses ^{22.} Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ takeno Cay C disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Exami physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the a detached for 9 I Inknown 9 Unknown s been signed by t should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s performed? Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 🖒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 01808 ~mn Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTROSE MO 6121 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 7, Sandra Ryan 2011 3:22 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hammonds Lane Center Brooklyn Park Anne Arundel Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs **Funeral** Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛚 Director 60 217-62-8043 Maryland Usual Residence of Decedent . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. It must if the state and Mental Hyglene. It ant if file as 23a or 28a-f sho tant if file as 23a or 28a-f sho lart if the matter of the Traumatic event, the Medical Examiner must be notified at iruy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director Anne Arundel Brooklyn Park 1 Yes 2 No MD 10e. Street and Number 10g, Citizen of What Country? Zip Code 21225 4 W. Jeffrey St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give Year or Dates Specify Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) deli clerk grocery store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Patricia Pettit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Manchester - sister 4 W. Jeffrey St; Brooklyn Park, Maryland 21225 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 State 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death)) Medical Examiner Sequentially list conditions, Examine consequence of cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{No} \) Pregnant at time of death Month Dav Vear cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of within 24 hours fiter death.

To the Funeral Director After this certificate has autopsy performed?
Yes 2 death? 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **AN**O 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation filled in by the Suicide 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 29b. Signature

State Registrar ddress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene D For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death KEED ERONICA SEPTEMBER 9:21 AM 2011 Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4cgCounty of Death HOSPITAL KINGE CHEVERLY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign unk Country) 8. Date of Birth 1 □ M 2 🕱 F Hours INEW SEX 10a. State 10d. Inside City Limits WASHINGTON D.C. 1 X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? N.H. BURROUGHS UJA 20019 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk unk 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Harper - sister 3848 26th Ave. Temple Hills, MD 20748 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2XX cremation 3 Removal from State Chesapeake Crematory 9/29/2011 Beltsville, MD 4 Donation 5 Ther (Specify) 11 State Anatomy Board 22. Name and Address of Facility 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate 20002 Interval Between Onset and Death Immediate Cause (Final CHRDIAC ARRHYTHMIK FATAL disease or condition resulting in death) Due to (or as a consequence of): 510N Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Date of delivery Year Month Day ontribute to the cause of death? o 3 🗌 Probably 4 💢 Unknown b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Other (Specify) urred

Medical Examiner Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

Director

28a-f show

Il Hygiene. I other than "natural", or items 23a or event, the Medical Examiner must be r

traumatic event,

and Mental F is marked o

permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic.

Physician/

be filed within 72 hours after death

Baltimore, Maryland 21215-0036

notified at

Director

Funeral

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Completed

Be

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To the Hospital or Attending Physician: The law requires that the death certificate be executed and-tran

ical E	resulting in death) Last	Due to (or as a consequent	uence of):				
<u>8</u>							
by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	23d. Date of delivery Month Day Year				
	Part II. Other significant conditions con	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.		use contribute to the cause of death?	
Completed					24a. Was an autopsy performed?		ble of
Be	25. Was case referred to medical examiner?			26. Place of Death (Chec	ck only one)		
2	1 ☐ Yes 2 🗶 No	lospital: 1 🏻 Inpatient 2 💢	ome 5 Residence	6 ☐ Other (Specify)			
Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju		
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factor)	ory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)	
Medical	(Check 2 Medical Examine	cian: To the best of my knowl er: On the basis of examination Practioner: To the best of my	n and/or investigation, i	in my opinion, death occurred :	at the time, date and plac	ce, and due to the cause(s) and manner:	stated.
_	29b. Signature and title of certifier		2	9c License number	20d D	late signed (Month, Day, Vear)	

State Registrar ned (Month, Day, Year,

DZ7577 09/17, DITAL DR CHEVERLY VI

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Physician/ 2011 24 Charlotte 04:40 Smith Naomi Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5707 Belle Vista Avenue N/A Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Hours Director 217-16-3173 1 🗆 M 2 💢 F 89 03/10/1922 MD 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 5707 Belle Vista Avenue 21206 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) U.S.F. & G. Keypunch Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **Blank** Zimmerman Barbara Anna William Raymond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau 5707 Belle Vista Avenue, Baltimore, MD 21206 Kevin F. Smith, Son Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State f X Burial 2 igsqcup Cremation 3 igsqcup Removal from State cemetery, crematory or other place Gardens of Faith 09/26/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 5305 Harford Road, Baltimore, MD 21214 22. Name and Address of Facility Olyandria 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ sarcino ma disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Unknown P.0. ģ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Stenosis Records, 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 XNo ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8022 BELAIR ROAF m. BA YIN OUNG parke Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Shafferman George Sept. 2011 7:45 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Essex Riverview Nursing Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Min. Months Hours **Director** 1**X** M 2 □ F 236-16-6637 Usual Residence of Deced 92 April 15,1919 West Virginia 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f MD Baltimore Edgemere 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 21219 United States 7244 River Drive Road death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) າ "natural", or iten ledical Examiner r 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Heelih and Mental Hygiene. I want if item 27 is marked other than "natural", or ury or other traumatic event, the Medical Exami ury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White Completed 3 X Widowed 4 □ Divorced Specify. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Aircraft Engineer Glen L. Martin Co. 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dacie Weaver John C. Shafferman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Sparrows Pt., MD 21219 2323 A Sparrows Pt. Road Louis C. Shafferman 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗵 Burial 2 🗌 Cremation 3 🗆 Removal from State Department Important: If any injury or once, Rocky Gap V.A. Cem. 9/27/2011 Flintstone, Maryland 4 Donation 🏂 🗌 Other (Specify) Signature neral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hrombosis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lost. Due to (or as a consequence of): Exami burial-tra Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 the for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ ☐ Live Birth ∠☐ Feed acc.
☐ Pregnant at time of death
☐ Unknown in the past 12 months? Day been signed by the a should be detached Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No Accident Investigation 6 Could not be filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

severly Schelle		1- For State Registrar		d / Department Certificate		nd Mental F	R	201 eg. No.	1 3110	
Physici Medical Exam				Scheller			2. Date of Dea Month Septembe	nth Day Year e r 24, 2011	3. Time of Death 1330 hrs	
		4a. Facility Name (if not institut 3 Loring Court Apt. C		per)	4b. City, Town, o	or Location of Deat	h	4c. County of Death Baltimore County		
Funeral Director		5. Social Security Number 213–62–4758	6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Ye Months Da		n.	rth(MM/DD/YYYY) 9. B 24, 1952 C		
W any		Usual Residence of Decedent 10a. State 10b. County	ounty 10c. City, Town or Location						10d. Inside City Limits	
ne Maryland or 28a-f show fied at once.	Director	Maryland Bal 10e. Street and Number						Og. Citizen of What Co	1 Yes 2 No	
th the M 23n or 2	Dig	3 Loring Court	Apt C			219		USA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral		12. Was Deced Armed Force 1 Yes vorced If Yes, Give Year	ent Ever in U.S. es?	Was Decedent of H If Yes, specify Cuba Yes 2 X N	an, Mexican, Puert	pecify Yes or No o Rican, etc.)	White, etc.	rican Indian, Black, hite	
72 hours a "natura"	eted by	15. Decedent's Education (Sp Elementary/Secondary (0-12	50 a 50	during	dent's Usual Occupa most of working lif			16b. Kind of Business	/Industry	
OO36 within within giene.	Completed	12 years	a Last)	Pi	rovider	10 Matheda Nove	o (Cinet Middle N	Day Care		
MD 21215-0036 11.2 should be filed within 7 th and Mental Hygene. 127 is marked other than umatic event, the Medica	Be C	Howard Carter	. ,			Madeli	ne Burme	eister		
MD 2 12 shoul th and M 127 is m	2	19a. Informant's Name/Relation Wayne Medlin	ship (Type, Print) SON		ling Address (Stre Martin R			nber, City or Town, State		
Baltimore, I bernit. Pages I and Department of Heal Important: If item		20a. Method of Disposition 1 XBurial 2 Cremation Donation 5 Other S		State crematory or	oosition (Name of co other place) idge Ceme	~ Se	otember , 2011	20c. Location - City o		
Baltir permit. 3 Departms Imports injury or		31. Signature of Friedal Service	Licenson	22	Name and Address Connelly 7110 Soll	s of Facility Funeral 1 ers Point	Home Of t Road.	Dundalk,P., Dundalk,MD	A. 21222	
Physician /Medical		23a. Part I. Enter the disease, o failure. List only one cause	on each line.	ed the death. Do not ente	er the mode of dying	g, such as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death	
£xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	nsive Atheronsequence of):	scieroti	c Cardio	Vascular	Disease		
	i Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause								
uted nd ransit		(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cond.	nsequence of):						
60, ate be executed hysician and e burial - transit	Medical	X UNPENDED		23a,27 per m	ne g920 1	0-5-11 v	t			
Box 68760, c death certificate be executed the attending physician and ed for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 ☐ Yes 2 ✔ No 9 ☐ Un	he 1 Live birth	at time of death 5	Fetal death 3 Other (Specify)	Ectopic pregna	ancy	23d, Date of deliver Month	y Day Year	
P.O. es that the igned by the detache	<u>a</u>	Part II. Other significant condi	tions contributing to de	ath but not resulting in the	e underlying cause	given in Part I.		bacco use contribute to		
Cords law requ has been	Completed						24a. Was a autop: perfor	sy prior to med? death?	utopsy findings available completion of cause of	
Vital Re ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	(Hospital:	itient 2 ER/Outpatie	_	e of Death (Check		Residence 6 V Othe		
c# - [₹] #	tion: To	1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pen	28a. Date of li (Month, Day	niury 28b. Time o	f Injury 28c. Inju	ury at Work? Yes 2 No		now injury occurred	r. Scene	
Divis pital or At ours after d teral Direct filled in by	Certification:	3 Suicide 6 Cou	d not be mined (Specify)	Injury - At home, farm, str	reet, factory, office	building, etc.	28f. Location (S or Town, Si		ural Route Number, City	
Div To the Hospital or within 24 hours afte To the Funeral Div completely filled in	Medicai (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner:On the basis of example and manner state	my knowledge, death occ xamination and/or investig	curred at the time, digation, in my opinion	ate and place, and n, death occurred a	I due to the cause at the time, date a	e(s) and manner as stated and place, and due to the	red. ne cause(s)	
H ¥ H S	Me	29b. Signature and title of certific		VI.	29c. Licens O.C.			29d. Date signed (Mo		
DO	-	30. Name and address of person	•							
St	ate	Pameta E. Southall, M		dical Examiner 90	00 W. Baltimor	e Street, Balti	more, MD 21	223		
Regist		31SEP*2*9*2011*ear)	Come p	. parker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:20 Edward Vincent Shannon 2011 September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore Stella Maris Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Director 216-20-7856 1 X M 2 □ F 82 July 2, 1929 Maryland 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 X No Marvland Baltimore Timonium 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2525 Pot Spring Rd. 21093 United States 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or in may injury or other traumatic event, the Medical Examin ane. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 🗌 Widowed 4 🗌 Divorced Specify: Completed white Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) salesman office equipment Be 2011 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Shannon Mary Shanahan 28, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 2525 Pot Spring Rd. Timonium, MD Catherine Shannon/wife SEPTEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2 X Cremation 3
Removal from State Green Mount Crematory Sep. 29,2011 Baltimore, Maryland 4 Donation 5 Other (Specify) J23. Name and Address of Fagility, Funeral Services of Dulaney Valley, Ohn O. Mitchell IV, Funeral Services of Dulaney Valley, P.A. 21. Signature of Funeral Service Licensee 200 E. Padonia Rd. Timonium, MD 21093 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate stock, or heart failure. List only one cause on each line Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition resulting in death) PROSTATE CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year SHANNON Pregnant at time of death signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes EDWARD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No , page 2 this certificate 2 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Hospital ည 1 Tes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: After the fulletely filled in by the fulletely filled in Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 22, 2011 Nora Lee Scanlan September 1:55 p м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Columbia Gilchrist Hospice Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 30, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Day, Year) 0 . 1940 Days 1 🗆 M 2 💢 F Months Hours Min. Washington **Director** 470-42-5208 Yrs. Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 No MD Columbia Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 10753 McGregor Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2X Married Maryland 21215-0036 1 Tes 2 XNo Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Guidance Counselor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy McMahon Malachy Scanlan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10753 McGregor Drive Columbia, MD 21044 permit, Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other trau Ronald Mayer/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 💢 Cremation 3 🔲 Removal from State Final Journey Crematory 09/24/11 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
MO1251Beverly L. Heckrotte, P.A. Clarksville, MD MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ BREAST CANCER resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of), and I-transit that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death ed by the a detached t 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician; The law requires 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page ; certificate 2 X N 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔼 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 🔀 Natural 5 Pending 1 Tes 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D64395 SEPTEMBER 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANE COLUMBIA, MIS 21044 DANIEUE DOBERMAN, MS 6336 State

DHMH 17 Rev 7/2009

Registrar

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

Registrar

а.п.

2011

28,

SEPTEMBER

BETTY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical Day 3 Month 1,45 PM 2011 pongbeng 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Gounty of Death Examiner 10wa 0/Um 516 Coun Hospite General 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) g. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Min. 06/30/1927 Massachusetts Yrs Director 84 014-20-2962 Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Directo₁ 1 Yes 2 X No Howard Columbia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 USA 12290 Green Meadow Drive 12. Was Decedent Ever in U.S.
Argued Forces?
1 🖾 Yes 2 🗆 No 19 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc 1944-1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 72 hours after white 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 1946 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Signe Ross Axel William Spongberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12290 Green Meadow Dr #117; Columbia, MD 21044 Alice Faye Spongberg - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Suneral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final Physician/ Rectal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) ned by the atten edetached for u Ectopic pregnancy in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires thin 24 hours after death.

the Funeral Director: After this certificate has been significate filled in by the funeral director, page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending iniurv work?
1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 46120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lepu Vo Louje 31. Date filed (Month, Day, Year 32. Registrar's Sinature State SFP 2 9 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6420 M CECILIA SHELTON R. eptemi her Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner GOOD SAMARITAN HOSPITAL BALTIMORE 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 M 2 X F Months Hours Min (Month, Day, Year) Country Director 1950 193-40-2196 Oct Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County **Funeral Director** th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Examiner must be notified 1x Yes 2 □ No <u>Baltimore</u> Md 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1332 Sherwood Avenue States United 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 Divorced **Black** Year or Dates 18a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Isiah Lindsey Ruth Strothers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Melvin Shelton / Husband 1332 Sherwood Ave. <u>Balt., Md.</u> 21239 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 10-4-11 Beltsville. 21. Sign tu e p Funeral Service List nsee 22. Name and Address of Facility Capitol Mortuary, Approximate 23a. Part 1. Enter the disease omplications that caused the death. Do not enter the mode of dying, shock, or heart failure. I net and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month Month Day Year Pregnant at time of death 1 Yes 2 Unknown ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be de ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 25. Was cas eferred to medical examinat?
1 Yes 2 No ours after death. eral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) To Be Hospital Other: R/Outpatient 3 DOA 1 Inpatient 2 S 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examiner (Check Certifying Aurse Practioner: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat 29d. Date signed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Amend Item 28a per me,g921,11/04/2011dhb

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend # 25,27,28a-f,29a, per ME, DVR G919 9/29/11 TR1

State of Maryland / Department of Health and Mental Hygiene

1- State Registrar amend #5,9,15,16a&b,17,18,19b,20a-c&22 Per FH C920

Per H C920

O | | 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ AUGUST 5:11 Claude Terrell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Prince Georges Hospital Cheverly 5. Social Security Number 4 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours May 2.9 4, Y14953 Director 58 579-72-9942 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Washingtoh 1 Yes 2 XNo DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20011 1006 Webster St NW 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Laborer unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) -unk ·unk 2 Sylvia Brockington Claude Russell Terrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Terrell - brother 912 Gallatin ST. NW Washington, DC 20011 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State
4 Donation 5 State (Specify) 1n State Riverdale Park Crem. 10/08/2011 Riverdale, MD. Amner At Home 908 Kennedy Wash. D.C 2120120011 Ronald Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death FALL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner SPINAL CORD COMPRESSION CEPTER CHICAN DEPOSITE BY MEDICAL EXAMINER Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Day Year Pregnant at time of death signed by the at d be detached fo 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year)

Jan. 22, 2011 unk 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 XAccident 5 Pending probable fall within 24 hours after death. **To the Funeral Director:** A 1 ☐ Yes 2 X No the 1 Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined unk bus stop Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier сопретед (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year se of death (Item 23a) (Type, Print 20185 3001 CHEVERLY. HOSPITAL 31. Date filed (Month, Day, Year) State Registrar

311

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Physician/ 1655 PM Leon Lincoln Thornton, Sr. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Agnes N/A Baltimore Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 D F Months Days Hours Min. Country) March 11, Year 925 219-12-6756 Maryland 86 Director Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location with the Maryland Director 1 Yes 2 No N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21216 USA 1121 N. Longwood Street items death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner rmed Forces?

Yes 2 \(\text{No} \) Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates "natural" Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Fort Howard Hospital Maintenance 6th Grade traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elizabeth Whiten Vsety Thornton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 N. Longwood Street Baltimore, MD. 21216 of Health item 27 Ruth Thornton - Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Department of P Important: If ite any injury or of once. cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Owings Mills, Maryland 10/3/2011 Carrison Forest Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD. 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (tras a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ue to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes ∠ ∟ 9 ☐ Unknown q I IInknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Linknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 2 🗌 No this certificate 2 - No Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death ospital or Attending Planding Planding Planding Steries after death uneral Director: After the 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical the Funeral Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ag 0 31. Date filed (Month, Day, State

Registrar

HORTON

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			30. Name and address of person who			rint)			- 50	221002 1:2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Arolfedible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 201 122:15 M Tartt September Gweneath Ann 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death PG Clinton Southern Maryland Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Social Security Number Hours Months Days 76 207-28-3509 Pennsylvania 09/04/1935 Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location X□ Yes 2 □ No Upper Marlboro PG 10g. Citizen of What Country? 10e. Street and Number USA 20772 16200 Candy Hill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married Black If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Computer Anaylsis 2 vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel Simpson Raymond Chilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20772 19a. Informant's Name/Relationship (Type, Print) 16200 Candy Hill Road; Upper Marlboro, MD Jesse E. Tartt - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 09/28/2011 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial PK 22. Name and Address of Facility Freeman Funeral Services of Funeral Service Lisenses 4594 Beech Road; Temple Hills, MD 23a. Part 1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SE PSIS disease or condition resulting in death) Due to (or as a consequence of) NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events

Ph_sician/ Medical Examiner

Department of Health ar Important: If item 27 is any injury or other trauonce.

Physician/

Medical

10a. State

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27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a

and Mental Hygier is marked other i

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine nding physician use as the burial by Physician/Medical ed by the a signed I Completed page 2 s

the Hospital or Attending Physician: The law requires that the death certificate be executed

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To the Funeral Director: After th completed filled in by the funeral

Division of Vital Records, P.O. Box 68760

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Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how inj	jury occurred		
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29d. Date signed (Month, Day, Year)

22

12011

State Registrar

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Richard Wayne Thornton September 18 2011 5:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Francis X. Gallagher Center Timonium Baltimore If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Country) Maryland Months Days Hours 220-74-5285 1 X M 2 □ F 61 09/11/1950 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show Examiner must be notified at Director Timonium Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 and Injury or other traumatic event, the Medical Event as must be no once. 21093 USA 2520 Pot Spring Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No þ Yes. Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucille Keller Richard Charles Thornton ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25311 11th Ave W; Seattle, Washington 98119 George Thornton - brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in 21. Signature of Funeral Service
Ronal H 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Par y, Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** week s a recurrent aspiration preumonitis /Medical Due to (or as a consequence of) Examiner regurgitation reflux

Due to (or as a consequence of): months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine esophageal dysmotility

Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 No 3 Probably 4 Unknown gastrointestinal hemorrhage due to 1 🗌 Yes certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No due to reflux recurrent hiccups 24a Was an 1 □Yes 2 □NO Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending after death.

I Director: Af in by the fur 1 ☐Yes 2 ☐No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death

 P^{M}

1 ☐ Yes 2 No

Year

29d. Date signed (Month, Day, Year)

Hospital or Attending Physician: 24 hours a within 2

Registrar

State

29b. Signature and title of confifier

30. Name and address of person who completed cause of dean (Item 23a) (Type, Print)

6701 N.

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charles St

32. Registrar's Signature

29c. License number

Da 5 a 0 5

Suite 4105 Towson, MD 21204

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State of Maryland / Department of Health and	Mental Hygiene
Ciaio Ci illan Jian	

For State Registrar Certificate of Death Rea. No 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 25, 2011 **Physician** 7:00 p M Trescott Catherine Α. /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Halethorpe 1814 Summit Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 29, 9. Birthplace (State or Foreign Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF 84 Yrs 216-20-2146 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County ? Is marked other than "natural", or Items 23s or 28s-f show traumatic avant, the Medical Examinar minist by colified at 1 ☐ Yes 2√☐ No Director Halethorpe Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 USA 1814 Summit Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ∐ Yes 2 DaNo If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 and Mental Hygiene. College (1-4or 5+) C & P Telephone Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Important: If item 27 is marked othany injury or other traumatic avera-17. Father's Name (First, Middle, Last) Be Bover Carrie Devine 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1814 Summit Avenue, Halethorpe, MD 21227 Bernard E. Trescott (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 XOther (Specify) Entombment Loudon Park Cemetery 9/29/11 Faltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensia 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) GENERALIZED CARCINOMATOSIS culco Physician /Medical Due to (or as a consequence of) aus **Examiner** METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. nding physicien Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the atter in the past 12 months?
1 Yes 2 No Month Day Year for 4☐ Pregnant at time of death 5 Other (specify) P.O. | detached 9 Unknown signed by t 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending Injury al or Attandin s after death. I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9/27/11 D 49274 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 N Rdling PC #3D I Cat MD Catons lle 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

SEP 2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Doris Vroman C. September 14,2011 3:30a [™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Future Care North Point Dundalk Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Days 067-20-8812 Director 1 M 2 F 87 New York May 18, 1924 10a. State aţ 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Dundalk Md. Baltimore 1 Yes 2X No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? items 23a Funeral 1912 Ormand Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 72 hours after 2 No 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) House Wife Own Home 7 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Allen Hayes Grace Ann Wakefield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 i Page 1 and 2 Aaron Vroman Son 1912 Ormand Road, Dundalk, Md. 21222 permit. Page 1 and 2 Department of Healt Important: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September cemetery, crematory or other place) 9 1 XBurial 2 Cremation 3 Removal from State Weedsport, New York injury (4 Donation 5 Other (Specify) 19,2011 Weedsport Cemetery 21. Signature of Funeral/Service Mensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. any 36a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between ALCIDENT mmediate Cause (Final disease or condition EREBROVASCULAR Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 thknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 ANO 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? s after death.

I Director: Aft in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) filled in by determined within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated SEPTEMBER 512011 cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienel Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 27 2011 **Physician** 9:15 AM 8 EDWARD WALLER JOSEPH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ALTHER WOODLAND NURSING HOME SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. March 26,1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F 82 Georgia Director 578-38-0907 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 10b. County show 77 is marked other than "natural; or items 23a or 28a-f shov traumatic svant, it s Madical Examinar must be notified at 1 XYes 2 No Silver Spring MD Montgomery Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20901 USA 1000 Daleview Drive death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1952 Black, White, etc. 2 should be filled within 72 hours after nand Mental Hygiene is marked other than "natural, or itel 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 1954 Specify: þ 3 X Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Industry Boiler Room Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Romilla Hunt Porter Waller 19b. Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathy Mancusi/Legal Guardian itam 27 i College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 iment of h 1 ▼Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ò permit. Page Department of Important: If any injury or once. Quantico Nat Cem | 8/7/11 Triangle, VA 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee 3821 14th Street, NW, Washington, DC 20011 M00969 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Minary trac **Physician** wee /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed HardON Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 🗌 Yes 2 🗌 No 1 ☐ Yes 2 X No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Innatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To tha Funaral Director: Al investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) 610 0 CITOU EMMHS HO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 9 2011 Registrar

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٠	Physicia Medic		1. Decedent's Name (First, Middle, L Emma Lee Whit	*				2. Date of Death Month	Day 13 Year	3. Time of Death 13:00 PM	
2000	Examir	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dr Union Memorial Hospital Baltimore							4c. County of De	eath	
	Funeral Director				ge (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 19/13/19	9.6	Birthplace (State or Foreign Country)	
		L	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation		19/13/1	930_1_	N.C.	
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	vith the 23a or 2	Funeral Director	10e. Street and Number 2400 Wilkens	λνο		10f. Zip Code	10g. Citizen of What Co 21223 USA				
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced	12. Was Decedent	No		ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, nite, etc. Black	
Maryland 21215-0036	thin 72 hours ene. than "natur he Medical I	Completed by	15. Decedent's (Specify only highest Elementary/Seconday (0-12) 12th		(Give i	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of work	ing	16b. Kind of Busines Private	o. Kind of Business Industry	
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	d 2 should I alth and Me 127 is mark er traumati		19a. Informant's Name/Relationship Lynnell McNea	,			and Number or Rura	al Route Number, C	Dity or Town, State, 2		
Baltimore,	Page 1 and ment of Hea ant: If item ury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐ Removal from State	20b. Place of Dispo cemetery, cren King Men	natory or other place norial F	e ark9/24	/2011 R		town, MD	
Balt	permit Depart Import any inj		21. Signature of Funeral Service Lice	ensee Ames) Av	Name and Address	ss of Facility Ma	rch F/H MD 2120	1101 E 2	. North	
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09	cate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Sever i	a consequence of): a consequence of):	ical act	ivity				
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ds, P.O.	luires that the dea on signed by the a uld be detached	by	Part II. Other significant conditions	contributing to death t	out not resulting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 🗆 Unknown	
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Division of Vital Records,	i a ii e	Certificate:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	t be	ury - At home, farm, stre c. (Specify)		Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,	
a	To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th	Medical	(Check 2 Medical Example (Check 2 Medical Example)	miner: On the basis of e	examination and/or invest	gation, in my opinio	n, death occurred at	the time, date and	d due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s) and manner stated. e, and due to the cause(s) and manner as stated.		
	1		29b. Signature and title of certifier alebi Q	uje of	MD	29c. License	43894		d. Date signed (Mor		
	8		30. Name and address of person who Ebrahim Taleb		leath (Item 23a) (Type, P	ersaille	y circle	e Apt+	CoTous	onemo	
	Stat Registra		31. Date filed (Manth, Day, Year) SEP 2 0 2011	32. Registra	ar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 1020 AM JAMES SEPTENBER DELCH 25 2º11 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Coctober 9, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1**X**□ M 2 □ F 53 220-66-2404 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐XNo Dundalk Directo Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 21222 7961 St. Monica Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify \$ 3 Widowed 4 Divorced "natural" Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than Transportation the Truck Driver 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be th and Mental F 27 is marked ot traumatic ever Catherine Jasek Alfred Welch Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7961 St. Monica Drive, Dundalk, Maryland 21222 Catherine Hooley Mother Health a Department of Heali Important: If Item 2 any Injury or other once. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) September 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland Bayview Crematroy 29, 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. VOLUME OVERLOAD Immediate Cause (Final ACUTE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner VENTRICULAR FAILURE 5 DAYS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as 1 IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death ed by the atten-3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ of Vital Records, 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page perform 1 ☐ Yes 2 ☐ No certificate director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 1 Yes 2 No impatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 2 this funeral 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) or Attending Injury death. 1 Tes 2 □ No the 1 after death Director: / 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 4 - Homicide City or Town, State) Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (check only 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier DES.500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LMD APORN)ANSOM 4940 Eastern Avenue, Baltimore, MD, 21224 32. Registrar's Signature 31. Date filed (Month) State Registrar

DHMH 17 Rev 1/2001 11595

Please	Type or	Print in	Rlack	Indelible Ink.	Fneure	All Co	nies Are	edible
L ICase	Type of	LIMITAL	DIACK	maennie mk.	Elignie	All CC	phies wie	Legible.

Margaret Williams	State of Maryland / Department of Health and Mental H 1-For State Registrar Certificate of Death		2011 ag. No.	31116				
Physician Medical Examine	Decedent's Name (First, Middle, Last) Margaret Williams	2. Date of Deat Month Septembe		3. Time of Death 1459 hrs				
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 6605 O'Donnell Street Baltimore	th	4c. County of Death					
Funeral Director		in.	th (MM/DD/YYYY) 9. Bir Foreig					
w any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
the Maryland tor 28a-f show tiffed at once.	Maryland N/A Baltimore 10f. Zip Code	10	0g. Citizen of What Cour	1 X Yes 2 No				
with the last 23a or be notified	6605 O'Donnell Street 21224 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5)			can Indian, Black,				
s after death with iral", or items 23 ainer must be no by Funeral	3 Widowed 4 Divorced If yes, Give Year 1 Yes, 2 1 No specify:		White, etc. Specify: Whi					
p, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. teat and Mental Hygiene. traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) The secondary (0-12) College (1-4 or 5+) Assembly Line Workers (1-4 or 5+)	etired)	16b. Kind of Business/I	•				
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica	James Thrappas Mary	ne (First, Middle, M Jeorgense	laiden Surname)	ı y				
MD 21 dd 2 should 1 dth and Mee in 27 is man numatic ev	19a. Informant's Name/Relationship (Type, Print) Robert Williams Husband 19b. Mailing Address (Street and Number or 6605 O'Donnell Street)							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		ptember , 2011	20c. Location - City or Baltimore,					
	22. Name and Address of Facility Connelly Funeral 1 7110 Sollers Point	t Road, I	Dundalk,MD.	21222				
Physician /Medical Examiner	23a. Plant \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease or complications as a Cardiomegaly with biventricular hype or condition resulting in death) Due to (or as a consequence of): Explanation of the condition of the condit	rtrophy		Approximate Interval Between Onset and Death				
5	or condition resulting in death) Due to (or as a consequence of): Emphysematous Change Sequentially list conditions, if any, leading to intrinduate Due to (or as a consequence of).	s, Embal	ming					
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	(Disease or injury that initiated C.						
iO, e be executed ysician and burial - transit	™ AMENDED 23a,pt.II,27,per me,g920 10-28-11 sm 23a per me g924 2-2-12 vt							
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physinal placetor of the funeral director, page 2 should be detached for use as the balical Certification: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ✔ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (Specify) 9 ☐ Unknown		23d. Date of delivery Month	Pay Year				
r, P.O. rres that the signed by to be detached by PP.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema		bacco use contribute to					
of Vital Records, P.O. sg Physician: The law requires that the ther this certificate has been signed by meral director, page 2 should be detected. TO Be Completed by P.	25. Was case referred to medical 26.Place of Death (Check	24a. Was a autops perform	sy prior to comed? death?	topsy findings available ompletion of cause of s 2 No				
F Vital F Physician: r this certifinal director, To Be C	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursi	ng Home 5 F	Residence 6 🗹 Other	Scene				
Division of points or Attending Phours after death. Internal Director: After filled in by the funeral Certification: T	1 X Natural 5 Pending Investigation (Month, Day, Year) 1 Yes 2 No		ow injury occurred treet and Number or Ru	ral Pauto Number City				
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by ledical Certifical	4 Homicide determined (Specify)	or Town, St	ate)	()				
To the Howithin 24 To the Formula Completel	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier		and place, and due to the	e cause(s)				
	Calment 7 O.C.M.E.		September 27, 2					
	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	, MD 21223						
State Registrar								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sentember 27, 2011 MARGARET SAULSBURY WARING 5:00P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore 8810 Walther Blvd Parkville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2**X**XF Months 220-14-2835 09/105/1922 Maryland 89 Director Yrs Usual Residence of Decedent 28a-f shov 10a, State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Tes 2 No Maryland Baltimore Parkville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8810 Walther Blvd 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes XX No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: "natural", Specify: 3XXWidowed 4 □ Divorced White Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) traumatic event, the Clerk Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Page 1 and 2 should be file treent of Health and Mental Ftant; If item 27 is marked of Charles Webb Saulsbury Edith Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Randall Buchman Gr-Nephew 48 N Prospect Avenue Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. Druid Ridge Mausoleum 10/03/2011 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 22. Name and Address of FMittchell-Wiedefeld Funeral Home Inc Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph, ici n disease or condition resulting in death) corona Medical Due to (or as a consequen & of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to jor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 1 Yes 2 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 \square Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours af

To the Funeral Di

completed filled in Medical 12 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of De 3. Time of Death Physician/ Mont -30AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Edgewater 1439 Shore Drive . Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days Hours Min 1 🗆 M 2 🕡 6/30/1927 Maryland 218-20-1093 **Director** 84 Usual Residence of Decedent 28a-f show with the Maryland at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2X No MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be r Funeral 21037 USA 1439 Shore Drive death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4X Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) If Hygiene. the 12 RN healthcare Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic even permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve once. 2 Elfie Judd Paul August Viereck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17106 Turtle Hill Road; Milford, Delaware 19963 Nancy Heath - daughter Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Balitmore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on year failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or se a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 No be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? this certificate 2 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 esidence 6 Other S ecity 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at After t Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural 5 Pending injury s after death Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier signed (Month, Day, Year) 30. Name and address of person 45 DEFENSE HWY, ANNAAOLIS, M.D.2140 JENEVIEVE DGHTFOOI-1 31. Date filed (Menth, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0355 M **Physician** 201 John /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Westver Moder 1 Year | If Under 24 Hrs. omerse 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month), Day, 9. Birthplace (State or Foreign **Funeral** Days Hours Min Mary land 1 M 2 □ F 218-48-4018 63 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumetic event, the Modical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director Westover MD Somerset 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 21890 USA 30420 Revells Neck Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11 Marital Status 1969-1 Never Married 2 Married XYes 2 ☐ No Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No if Yes, Give Year or Dates: 2 3 Widowed 4 □ Divorced 1974 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) none none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marie Maglov Leroy Worsham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 705 Compass Rd #333; Middle River, MD 21220 Frank Worsham - brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □ Donation 5 🛛 Other (Specify) in state 21. Signature Puneral Service 22. Name and Address of Facility State Anatomy Board rector 655 W. Baltimore St; Baltimore, MD 21201 w Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner tal luve Sequentially list conditions, Examiner if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 3 Probably Junknown 1 ☐ Yes 2 ☐ No Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 2 NO NO 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Injury 5 ☐ Pending after death. 1 □ Yes 2 □ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760, To the Hospital o within 24 hours aff To the Funerel Di completely filled in

> State Registrar

Medical

4 - Homicide

29b. Signature and title of contries

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
TO COM CLEM MD 30420 Revells Neck Rd, Westover, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

V

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🞢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0058 70)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year Month EdWARA 2:30PM 20 /Medical 2011 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bûlimore If Under 1 Year If Under 24 Hrs. CLRC 5. Social Security Number Date of Birth (Month, Day, Year) 07/15/1950 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Days 1 M 2 ☐ F Months Hours Yrs. Mississippi Director 383-52-5451 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Ever sinks must be notified at 10d. Inside City Limits Anne Arundel Pasadena 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 764 204th Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No8/23/67 If Yes, Give Year or Dates: 1/21/71 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🛣 No Completed by 3 ☐ Widowed 4 🕅 Divorced 1/21/71 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry tal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) painter home improvement permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked othe any lighty or other traumatic event, other. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Dryden Wood Margaret Farley ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey Wood - daughter 764 204th Street; Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State 21. Signa Land Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stare Live Disease Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner vilis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) attending physician a for use as the burial-To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending hywaidar. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 452 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

LOCH

2 9 2011

3900

Box 68760.

P.O.

Division of Vital Records,

XIANGROUSS Baltimore;

29d. Date signed (Month, Day, Year)

2011

and manner stated.

MID

RAVEN BLVD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type of Print in Black in Helink. Ensure All Copies Are Legible. amend #30 Per DVR G919 2011 JH State of Maryland / Department of Health and Mental Hygien? 0 | | amend #11,12&19a Per ANA BD G921 11/02/2011 JH Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death \$petember 22, 2011 P_{M} Physician/ 11:35 Leo Dillon Wallett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford **Examiner** Bel Air Upper Chesapeake Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth 6. Sex 1 M M 2 □ F Funeral Days Hours Min 08^{(M}02^{h, Pay}9^Y235 Yrs Maryland Director 220-20-7343 Usual Residence of Decedent or 28a-f show 10d, Inside City Limits 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 No Aberdeen Harford MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 23a 21001 947 So. Stepney Road 12. Was Decedent Ever in U.S. Armod Forces? 1424 Yes 222 No If Yes, Give Year or Dates. 143-11 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status or i Black, White, etc. 1 Never Married 2 Married Completed by White 1 ☐ Yes 2 X No Specify. 143-154 Specify "natural", 3XXWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) di. ygjene. Elementary/Seconday (0-12) College (1-4 or 5+) AT&T systems tech 10 or other traumatic event, Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Josephine Cardwell ပ William Edward White and N 19a. Informant's Name/Relationship (Type, Print) granddaughter 947 So. Stepney Road; Aberdeen, MD 21001 Lepartment of Health an Important: If item 27 is n any injury or other *** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Foard 21. Signature of Euneral Service 655 W. Baltimore St; Baltimore, MD 21201 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) uma Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or any consequence of) the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No detached for Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? 1 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 \(\text{Yes} ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director, After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No M Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined wrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one)

Irina Kitiyanskaya

29b. Signaturé

Baltimore, Maryland 21215-0036

9

122-

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Irina Kitiyanskaya 500 Upper Chesapeake DRive Bel Air ,MD 21014

29c. License number

29d, Date signed (Month: Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROBERT <u>6:56</u>ª м WATTS Medical SEPT 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number 8. Date of Birth
(Month, Day, Year)
July 31 **Funeral** If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Days Min. 1 X M 2 D F Months Hours Country) **Director** <u> 578 - 56 - 8366</u> 194 Usual Residence of Decedent or 28a-f show 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director D.C. 1 Kyes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2700 Jasper St., S.E. 20020 <u>United States</u> death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 Yes If Yes, Give 1 Nes 2 No Specify: Specify: Completed 3 Widowed 4X Divorced B1ack Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry 72 } (Specify only highest grade completed) 1 and 2 should be filed within 77 Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) 12th College (1-4 or 5+) the Cab Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Archie Watts <u>Annie Williams</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa West / Daughter 183 Elmira St. SW Wash. DC Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of I Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 9 - 29 - 11Beltsville, Md 21. Signat ve of Funeral Service Licens 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave.. NE Part 1. Enter the disease or complications that daused the dearly bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. 23a. Part 1. Enter the disea Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ FATAL CARDIAC ARRHYTHMIA Medical Due to (or as a consequence of) **Examiner** HYPERTENSIVE CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine END STAGE RENAL DISEASE or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2X No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No After this certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural 5 Pending injury Accident Suicide Investigation 6 Could not be after death filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) e and address of person who completed cause of death (Item 23a) (Type, Print) Rphnell Cumberbatch, M.D. 3001 Hospital Dr. Cheverly. 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marjorie A. Yeagle Sept. 2011 4:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium Social Security Numbe 8. Date of Birth (Month, Day Year) Jan. 12 1932 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Hours Min. 79 214-34-4406 Director Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho arrany highry or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2X No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12101 Tullamore Ct. #303 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Nurse - RN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SEPTEMBER 28, Melvin Barnard Catherine Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Craig Yeagle/son 201 Burning Tree Rd., Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 10/1919 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4 Donation 5 Other (Specify) 21. Signature of Uneral Service Licens 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. Michael 刀 10 W. Padonia Rd., Timonium, Ract 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Opset and Death ND STAGE DEMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit Cause (Disease or iinjur) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 22 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier R043580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS, 2300 DULANEY VALLEY ROAD TIMONIUM MD21093 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

MARJORIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	partment of Health and N	Mental Hygie	ne	
			1 - State Registrar C6	rtificate of Death	Reg.	No 2011	31124
	Physicia	m/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
.X.	Medic		Jack Robert York		Sept. 2	27, 2011	8:37 A ^M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
الموسود	Formul		Gilchrist Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Towson If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimore	pplace (State or Foreign
	Funeral Director		161_E0_7271	Months Days Hours Min.	(Month, Day, Yea		ntry)
		١.	Usual Residence of Decedent //		12/15/19	40 Tex	as
	yland if sho	ţ	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mar 28a-	Director	MD Baltimore Towson				1 Yes 2 X No
	th the		10e. Street and Number	10f. Zip Code		Citizen of What Cou	untry?
	ems 2	Funeral	900 Southerly Road, Apt. 318 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21204	<u>`</u>	J.S.A.	
(0	or ite	by Fi	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ameri Black, White	
030	rsaft mal", Exar	edb	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No Specify:		Specify: Whi	te
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed		edent's Usual Occupation kind of work done during most of work	ing 16b	o. Kind of Business/I	
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22	d wit dygie ther nt, th	ادہ ا	12 Pt	notographer		Computer	
Maryland	be filed ental Hy ked oth ic event	10E			ne (First, Middle, Maid		
ary.	should and Me is marl raumati		Homer York 19a. Informant's Name/Relationship (Type, Print) 19h. Mail	Melva ing Address (Street and Number or Run		opper	Cadal
	12 shalth ar 27 is r trau			Southerly Road, A			· ·
re,	1 and of Heal item		20a. Method of Disposition 20b. Place of Disp	osition (Name of		Location - City or 1	
m	Page ment o ant: If ury or			matory or other place) fts Registry 09/2	8/2011 на	anover, Ma	aryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ı	21. Signature of uneral Service Liminsee	2. Name and Address of Facility An	atomy Gift	ts Regist:	CY
_	90 = 8 9		120	7522 Connelley Dr.	, Ste. P,	Hanover,	MD 21076
			23a. Part 1. Enter the disease of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
je g	h sician/		Immediate Cause (Final disease or condition RESTRICTLY	ELUNG DISE	ase		Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):	DELUNG DISE DARTHRITIS			
		e e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	DARTHRITIS			X017125
	red	Examiner	cause. Enter Underlying Cause (Disease or injury				
	execu in and ial-tra	E	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
9	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and ately filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dical	d	. <u>-</u>			
876	tificat ng ph	w	IF FEMALE:				
9 X	eath certifica attending p	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3			23d. Date of deliv	*
8	e dear the at hed fi	ysic	1 Yes 2 No 4 Pregnant at time of death 5 Unknown 9 Unknown	Other (specify)		Month	Day Year
P.O. Box 687	nat the	F.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
S, T	requires that the dec been signed by the s should be detached	Completed by Physician/M	CORUMNEY ARTERY DISEASE	2	1 ☐ Yes	2 No 3 □ Pro	obably 4 🗆 Unknown
ord	peen shoul	lete	SPINAL STENOSIS		24a. Was an	24b. Were auto	opsy findings available
ec	The law ate has page 2	mg	STINK L STENUSIS		autopsy performed	prior to co	ompletion of cause of
Division of Vital Records,	sician: The certificate irector, pag		25. Was case referred to predical	26. Place of Death (Chec.	1 Yes 2 2	No 1	2 No
<u> </u>	Physician: T r this certifica aral director, p	면	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 Other (Specif	W HOSPINO
o	ng Pt fter th Ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) injury		28d. Describe how in		
<u>o</u>	tendi leath. or: Ai the fu	ijies	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No			
<u>N</u>	spital or Attending Pours after death. eral Director: After tilled in by the funera	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	28f. Location (Street City or Town, Sta		al Route Number,	
	a) and mannor as sta	tod					
	e Hos 124 h e Fun e Fun	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred a	t the time, date and pla	ace, and due to the ca	ause(s) and manner stated.
	To the Hospital within 24 hours a To the Funeral C completely filled		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
			In Atom	D46360	Se	PTEMBOR	27.2011
	20		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	Street Bi		110 7
	D.0		NICHAR A ANDRONMO 6701A	ORTHCHARLES	TRAN BI	PLITIMORE /	1021264
	Stat	e ır	31. Date filed (Month, Day Year) 32. Registrar's Synature				,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g919 9-29-11 yt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. N2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 7:00A M Victoria Zananiri Sept. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Timonium 2124 Eastridge Road Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth March Day4 Year) 1919 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🛛 F Hours 220-90-9791 92 Director Jerusalem Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 1 🗆 Yes 2 🗓 No Timonium MD Baltimore 10e. Street and Number 10f. Zip Code ö ms 23a or must be r 10g. Citizen of What Country's 2124 Eastridge Road 21093 IISA death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ò þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
The 17 is marked other than "natural", or any or other traumatic event, the Medical Exami, un yor other traumatic event, the Medical Exami. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Zananiri Tawfig Zananiri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2124 Eastridge Road Timonium, MD 21093 Aida Barghout/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Dufaney Valley Memorial_Gardens Department of H Important: If ite any injury or oth once, Date 28, 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Sept. 2011 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 21. Signature of Euteral Service 22. Name and Address of Facility Michael Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 23a. Fort 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CONGESTIVE HEART PAILURE Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** HEROS CLEROTIC HEART Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of g physician and as the burial-transit Exami resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 199 CERTONSION, HYPERLIPOPROTEINEMIA Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown ARTERIOS CLEROTIC HEART DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy certificate 1 Yes 2 No Yes 2 No the Hospital or Attending Physician: the Funeral Director: After this certific npleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: Other Sesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work death. 2 Accident 1 Yes 2 No M Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined after within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signator 29c. License number 29d. Date signed (Month, Day, Year) D0022633 9/26/11

DHMH 17 Rev 7/2009

State Registrar Jørge C.

110 West Rd., Towson, MD

d add ess of person who completed cause of death (Item 23a) (Type, Print)

Secada-Lovio, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ D. Avillanoza September 13, 2011 Maria Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George 9211 Lancelot Road Ft. Washington Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F 268-66-9974 97 0970871914 Philippines Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director notified at 28a-f Maryland| Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be i **Funeral** I 9211 Lancelot Road 20744 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. event, the Medical Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2xxNo Specify: Specify: Filipino Completed XX Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than ' id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) years School Principal Philippine Public School Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Cayetano Briones Luisa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zacarias D. Avillanoza Jr./Son 9211 Lancelot Road Ft. Washington, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 9/22/2011 Pura Tarlac, Philippines 4 Donation 5 Other (Specify) Pura Public Cem. 22. Name and Address of Facility George P. 21. Signatur Funeral Service Mcensee Kalas Funeral Home PA 14 6160 Oxon Hill Rd. Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ HTM disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): death certificate be executed use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month signed by the a ld be detached for 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4XXUnknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica of Vital Be 25. Was case referred to medical upleted filled in by the funeral director, 26. Place of Death (Check only one) 1 Yes 2 X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending Division 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined o the within 24 hou. "he Funeral D' Medical 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🔲 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D10980 al 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6357 Oxon Hill Rd. Oxon Hill, Maryland MDGhazala Shah 20745

7:44A

10d. Inside City Limits

1 Yes 2 KNo

20744

20745

Year

Day

Onset and Death

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1 4 2011

Jacks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death September 19,2011 Physician/ Bernice Hazel Arnold 2:00 p.m.^M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 21083 Arnold Road Abell Mary's 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Days Hours Min 05/20/1938 North Carolina **Director** 215-64-6886 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2X No Maryland St. Mary's Abell 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21083 Arnold Road 20606 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Completed White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Mafra Bailey Oscar Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peregrine Way, Hollywood, MD 20636 Mary Sue Joy/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Charles Memorial Cem 09/23/2011 Leonardtown, Maryland Funer Dice Licensee
Edward N. Brinsfie 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Cell LVNG 2 cancer Ph. ici n quamous disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami that initiated events resulting in death) Last attending physician and for use as the bunal-trar Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by severe acrtic stenosis Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed pinous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy Yes 2 XNo • Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred atural injury 5 Pending Accident Investigation completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🔀 crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0055682 attendin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nowar M. Wilkinson, MD 23130 Moakley St., Leonardtown, MD 20650

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Monti

12:52 OR HUMAS TOD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 23 Thomas Edward Jr. 2011 Bishel. 12:50 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Hospital E1kton Ceci1 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign November 15, 1 🗶 M 2 🗆 F Months Days Hours Director 222-20-9736 73 Delaware Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits or 28a-f Maryland| Ceci1 1 Yes 2 X No E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 140 Blair Lane 21921 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Ty Yes 2 No ٥r 1 Never Married 2 Married Black, White, etc. Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. "natural", 3 Divorced 4 Divorced Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Il Hygiene. (Give kind of work done during most of working Automobile life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Area <u>Manager</u> and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ည Thomas E. Bishel, Sr. Marie T. Donovan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trat once. Anna F. Bishel/Wife 140 Blair Lane, Elkton, Maryland 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State September 27, R.A. Ferris & Co., 4 Donation 5 Other (Specify) Inc. West Chester, PA 2011 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signatu of Funeral Service Licensee 103 W. Stockton St., Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Myocardial Acute Infaction disease or condition Medical resulting in death) Due to (or as a con e uence of): Examiner 2 days Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Severe cardiomyopath 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 은 Other: 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury 28b. Time of 28c 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28c. Injury at Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) tage and title of certifier 29d. Date signed (Month, Day, Year) D66176 09/23/2011 maine MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA, MD; 106 BOW St., MD Elktom 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Glenn Samuel Bachtell Physician/ Month Day 24 Year | Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1 → M 2 □ F Hours Min 214-28-0072 Yrs Director 80 May Maruland Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland 10d. Inside City Limits notified at 10c. City, Town or Location irector 1 X Yes 2 No Maryland Washington Smithsburg $\bar{\Box}$ 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 12 Eckstine Court 21783 U.S.A. items ? within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian d Forces rces? Air 2 No F859e re 1956 ates. 1956 rmed For XYes Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. "natural", Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Certified Public Accountant Accounting and Mental Hygie is marked other Be Page 1 and 2 should be filed went of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel A. Bachtell Irene Schildt traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann L. Bachtell 12 Eckstine Crt. Smithsburg, Maryland 21783 (Wife) other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place October Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Cemetery 2011 . Signature of Funeral Service Licenseg MO1414 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MYd Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical requires that the death certificate be Box 68760 the attending IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an the Hospital or Attending Physician: The law certificate has autopsy betes Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ည 1 Impatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 \quad Yes 28d. Describe how injury occurred injury Natural 5 Pending death. 2 Accident
3 Suicide 2 🗆 No Investigation within 24 hours after deat To the Funeral Director: upleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 3 SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year,

2 9 2011

32. Regist ar's Signat

11-07049 Yaw Bonsu Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 31130 2011 Certificate of Death 1- For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day September 19, 2011 0614 hrs * -al Examine Yaw Osei Bonsu 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Baltimore Washington Medical Center Glen Burnie Date of Birth (MM/DD/YYYY)Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Country) Ghana 08/08/1960 Director 51 Yrs 215-27-9131 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No Odenton or items 23a or 28a-f show must be notified at once. Anne Arundel Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once, Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number u.s.A. 21113 1903 Cannon Ball Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? 1 Never Married 2 X Married African-American
Specify: 2 X No 1 Yes 1 Yes 2 X No specify: If Yes, Give Year 4 Divorced 3 Widowed 15. Decedent's Education (Specify only highest grade completed) ੬ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Health Care Licensed Practical Nurse Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Afua Kwaa Eno Bonsu Yaw Osei Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1903 Cannon Ball Court, Odenton, Maryland 21113 Christiana O. Bonsu - Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 11/08/2011 Kumasi, Ghana Old Tako Cemetery 4 Donation 5 Other Specify 22. Name and Address of Facility Hines-Kinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 Liguson 23a. Part I. Enter the disease, or coordications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death Medical a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **∠**xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27 per me g921 11-2-11 vt signed by the attending physician is be detached for use as the burial -X UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FFMALE Year Month 2 Fetal death 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown page 2 should be Completed 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Other₄ Nursing Home 5 Residence 6 Other: After this 2 No 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No hours after death.

uneral Director: / 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 6 Could not be Suicide within 24 hours at To the Funeral D completely filled determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 21, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Donna M. Vincenti, MD 31. Date filed (Month, Day Year) 32. Registrar's Signature Registra

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		_	For State Registrar		,		tificate				Reg. No.	011	31101
ı	Physicia Medic		Decedent's Name (First, Middle, Last) Marlin Triece 1	Bohler	Jr.					2. Date of Dea Month Septem	Day	Year 201	3. Time of Death 1 6:23 a M
بالمناور	Examir		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dec							_		County of Deat	th
	Funeral		30060 Deal Island 5. Social Security Number 6. Sex	7. Age	(In yrs. la	st birthday)	If Under		f Under 24 Hrs.	8. Date of Birl	th .	nerset g. Bir	thplace (State or Foreign
	Director		214-36-6099 1 X	M 2 🗆 F	73	Yrs.	Months	Days	Hours Min.	02/26/	1938	Mar	yland
	yland f show ed at	tor	10a. State 10b. County			, Town or Loc		-					10d. Inside City Limits
	r 28a- notifie	Director	Maryland Somerset 10e. Street and Number		Prin	cess A	Anne 10f. Zip	Code			10a Citi	zen of What Co	1 Yes 2X No
	is filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	30060 Deal Island	Road			218				rog. Oit.	USA	,
(0	er death or item niner n		11. Marital Status 1 ☐ Never Married 2 😾 Married	. Was Decedent E Armed Forces? 1 X Yes 2 If Yes, Give	verin U.S Vatic	nal 13. V				ecify Yes or No- Rican, etc.)	1	14. Race - Ame Black, White	
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215-	72 hc an "na Medic	mple	15. Decedent's Educ (Specify only highest grade		. 16		lent's Usua kind of wor O NOT use	k done dun	on ing most of work	king	16b. Kir	nd of Business	Industry
212	led within Hygiene. other tha ent, the N	ادہ ا	Elementary/Seconday (0-12)	College (1-4 of 5		Manage	er					ware	
land	ould be filed d Mental Hy marked oth matic event	일	17. Father's Name (First, Middle, Last) Marlin Triece Bohle	er				1		ne (First, Middle, da Calla		iurname)	
Maryland	S S		19a. Informant's Name/Relationship (Type, Barbara A. Bohler/	•						al Route Numbe			p Code)
Baltimore,	age 1 and 2 s ent of Health a nt: If item 27 i y or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☑ Donation 5 ☐ Other (Specify)	moval from State	Ce	lace of Dispo emetery, cren	natory or of	ther place)	try 9/1	Date 2/2011		cation - City or	
Baltin	permit. Page 1 a Department of F Important: If ite any injury or ot		21. Signature of Fundamental Service License.	3/4	e	22	Name and	d Address	of Facility				Association
		Н	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of	ations that caused	the death								
, it	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)			Fa	160	Re					Onset and Death
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	ed sit	Examiner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a									
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Box 6876	death certificate ne attending phy: ed for use as the	JW/W	ZOD. Was decedent program	If yes, outcome of			Ectopic p	vognanov.			2	23d. Date of de	elivery
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tal	cian: 1 ertifica ector, p		25. Was case referred to medical examiner?	wital:					e of Death (Chec		1		
ξ	Physic this c	임	1 ☐ Yes 2 ☐ No 27. Manner of D ath	spital: 1 Inpatie 28a. Date of injur		ER/Outpatier 28b. Time of		Other: 8c. Injury a		ome 5 Residence 128d. Describe h			cify)
o uo	ending eath. or: After ne fune	ficate	Natural 5 Pending 2 Accident Investigation	(Month, Day		injury	M	work?	s 2 🗆 No	260. Describe i	iow irijury	occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within F14 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc			eet, factory	, office		28f. Location (\$ City or Tox		Number or Ru	ıral Route Number,
	Hospi 24 hour Funera eted filk	Medical	, – – – – – – – – – – – – – – – – – – –	: On the basis of ex	kamination	and/or invest	tigation, in r	ny opinion,	death occurred a	at the time, date a	and place,	and due to the	cause(s) and manner stated.
only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, 29b. Signature and title of certifier 29c. License number							oo, and due to th		signed (Mont				
	-01		30. Name and address of person who com	Mated cause of de	eath (Item	23a) (Type 5	Print)	24	0/2		9/	12/1	
	14		3 65 / Enth Si			oke C		mv	0				
	Sta Registra		31. Date filed (Month) Pary 3	32. egistra	r's Signat	ure	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ SEPTEMBER 11, 2011 HERMAN BAKER 2:00 P M **JEROME** Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN, MARYLAND If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Min 1 X M 2 🗆 F Yrs EASTVILLE, VA Director 78 AUG 21,1933 222-20-4329 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2X No MARYLAND WORCESTER BISHOPVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral UNITED STATES 9449 MORRIS ROAD 21813 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black White etc. 1 X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: BLACK 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **COOK** FOOD SERVICE 5TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ DANIEL CATHERINE BAKER WEST 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. BOX 184 BISHOPVILLE, MD 21813 LOVELL BAKER - HUDSON (NIECE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State SEP 19,2011 MILLSBORO, DE 4 Donation 5 Other (Specify) FIRST STATE CREM. CTR. 22. Name and Address of Facility 21. Signature of June al Septice Licensee WATSON FUNERAL HOME PO BOX 125 MILLSBORO, val caused the death. Do not en the node of dying, such as cardiac or respiratory arrest, or each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death ntriculing to deal but not resulting / the underlying cause 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Hermon 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No certificate of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 🔲 Yes 1 Npatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden 3 Sulcide work? 1 ☐ Yes 2 ☐ No 5 Pending Division Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner on the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Prayloner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 Certifying Nurse 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who thon 31. Date filed (Month, Day, No. State 5 Registrar

29/168

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Year Month 5:15 AM Physician/ 2011 Sentember Louis C. Barnard Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Harkord Bel Upper Chesapeake Medical Center Air 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Under 1 7. Age (In yrs. last birthday) Months °Funeral Hours 1 M 2 F 56 213-78-5672 Maruland 06/08/1955 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 🌠 Yes 2 🗆 No Havre de Grace MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21078 1237 Ontario Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married by 1 Yes 1 ☐ Yes 2 🔀 No Specify: White Baltimore, Maryland 21215-0036 Completed 3 Widowed 4 Divorced Year or Dates. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Disabled Disabled Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mary Louis Schroeder Homer Nelson Barnard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1303 Ontario Street Ext., Havre de Grace, MD 21078 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trat once. Shirley Graves (Cousin) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery 109/23/2011 | Havre de Grace, MD 22. Name and Address of Facility Zellman Funeral Home, P.A. Signature of Funeral Service Licenses 123 S. Washington Street, Havre de Grace, MD 21078 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List in the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final inknown Preumoria Physician/ disease or condition Medical resulting in death) Respiration Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events Due to (or as a consequence of) Hauk rena executed Due to (or as a consequence of) resulting in death) Last ending physician a use as the burial-Septic shock Physician/Medical Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ___ 23b. Was decedent pregnant Year Month Day in the past 12 months?
1 Yes 2 No Pregnant at time of death
Unknown After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown acidosio Metabolic Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? hypermagnesemia 24a. Was an autopsy performed? 2 🗌 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Npatient 2 ER/Outpatient 3 DOA မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death Certificate: Hospital or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after death Funeral Director: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier September, 20, 2011 D0065421 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bul tir Manyland 2014 500 Upper Cherapeaks moi, Christa Fister, MD 32. Registrar's Signature William !

Registrar

Barnard

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		•	State Registrar			Cer	tificate of L	Death	Reg	g. N2. 0	31134	
I	Physicia Medic		Decedent's Name (First, Middle, Last) JULIA MAE BR	OCKINGTON				·	2. Date of Death Month September	01, 2011	3. Time of Death 7:00 A M	
100	Examin		4a. Facility Name (if not institution, give s					SPRING		4c. County of Deat MONTGOME		
	Funeral		HOLY CROSS HOSPI 5. Social Security Number 6. Security Number	x 7. Age	(In yrs. la	st birthday)	SILVER If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign	
	Director		579-42-7665 Usual Residence of Decedent	□ м 2 ⊠ F	79	Yrs.	Months Days	Hours Min.	þ1/16/193	2 Co	DC DC	
	faryland Ba-f shov tified at	ector	10a. State 10b. County MD Montgomer	v	,	, Town or Loc singto					10d. Inside City Limits 1 Yes 2 □ No	
	ith the N 23a or 2 it be no	Funeral Director	10e. Street and Number	<i>J</i>			10f. Zip Code 10g.			g. Citizen of What Co Jnited Sta	Citizen of What Country?	
	ath w	nue	3000 McComas Ave	12. Was Decedent Ev	er in U.S	i. 13. V	20895 Vas Decedent of H	ispanic Origin? (Spe n, Mexican, Puerto		14. Race - Ame		
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 ☐ Never Married 2 ☐ Married 3 😾 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 21 1 1 If Yes, Give Year or Dates.	No		Yes, specify Cuba		Rican, etc.)	Black, Whit	e, etc. Black	
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ylar	d be f Menta arked atic ev	임	Emerson Davis					Roxie W	illiams			
Maryland	d 2 shoul alth and I 1 27 is m	7	19a. Informant's Name/Relationship (Type Tyrone N. Thomps							City or Town, State, Zi shington,		
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Ħ	nit. Pagartmer artmer ortant injury e.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Lio	ee	FO	rt L1n	. Name and Addre	ss of Facility Pot	oe Funera	1 Homes,	P.A.	
Ba	Depar Impor any ir	1	Kurta A	1 MOL	085					ville, MD		
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-	Medical Examiner		resulting in death)	a. Due to (or as a		loliti						
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P.O.	at the od by t detach		9 Unknown Part II. Other significant conditions co	ntributing to death bu	ut not res	ulting in the u	inderlying cause gi	ven in Part I.	23e. Did toba	acco use contribute t	to the cause of death?	
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Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director.	Medical Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc			eet, factory, office	7	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,	
	n 24 hour	Medica	29a. Certifier (Check (Check only one) 1 Certifying Phys 2 Medical Examination only one) 3 Certifying Nurs	ner: On the basis of ex	amination	and/or inves	tigation, in my opini	on, death occurred a	at the time, date and	place, and due to the	e cause(s) and manner stated.	
	Northi Voithi Comp		29b. Signature and title of certifier Barbaro Au				29c. Licens	e number		09/01 O9/01	nth, Day, Year)	
0	6		30. Name and address of person who o	ompleted cause of de	eath (Item	23a) (Type, I	Print)					
1			Barbara Supanich	M.D. 150	00 Fo	orest	Glen Road	l, Silver	Spring,	MD 20746		
	Sta	te	31. Date filed (Month, Day Year) SFP 1 5 201	Variable D	o oigilia	alle						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Septentier Physician/ Norbert Bolev Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctores Community Hospital Lanham Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthdav) **Funeral** 1 X M 2 D F Hours Min. (Month, Day, ar 29 Country: Months Yrs 578-56-8115 Director 68 Mar 1943 Penna Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Yes 2 No Maryland Prince Georges New Carrollton 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral and 2 should be filed within 72 hours after death with 5911 89th. Ave. 20784 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. o, 1 Never Married 2 Narried þ 2 \square No 1 ☐ Yes 2 ☐ No Specify: 21215-0036 "natural", Completed 3 Widowed 4 Divorced White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Dept. Of Vets. Affairs life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Locks_{mith} 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P Nelson Boley Zita A. Sherry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5911 89th. Ave. New Carrollton, MD 20784 Shirley E. Boley (Wife) Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 9/13/2011 Beltsville, MD 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signatur of Lineral Service Licensee 9013 Annapolis Rd. Lanham, MD 20706 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at only one cause on each line. 1. Enter the disease, Approximate Interval Between Onset and Death ock, or heart failure. mediate Cause (Final ANCER Physician/ UNG disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit PNEUMONIA and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 No signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by ARTERY 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical in 24 hours after death.

he Funeral Director: After this certific pleted filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ Nation 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending 1 🗌 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 1005095 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2400 RIVERDALE MO 2518 KENILLSDRIN AVE SULTE 31. Date filed (Month, Day State SEP 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September Physician/ Q VOY Medical 4a. Facility Name (it not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 415 If Under 24 Hrs 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign last birthday **Funeral** Hours Months 69 1944 Director of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must he motified of 10b. County 10c. City, Town or Location 10a. State Director 1 🗷 Yes 2 🗌 No \mathcal{D} 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 20 90 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 M No If Yes, Give Year or Dates Specify Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Biotene Elementary/Seconday (0-12) College (1-4 or 5+) river Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 👪 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State Parkton nc eptember 16,2011 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 2 1 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes Division of Vital completed filled in by the funeral director, 25. Was case referred to fiedical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at work? 1 🔲 Yes 28d. Describe how injury occurred injury atural 5 Pending 2 🗌 No Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying NUse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER Day Physician/ 2011 6:38 A M ROBERT ALLEN CULTER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** 1 XM 2 🗆 F Months Days Hours October 29, Maryland 215-50-5162 61 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director Frederick Frederick Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 must be n 21701 Funeral United States of America 2498 Five Shillings Road permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Education Educator Be 18. Mother's Name (First, Middle, Maiden Surname) **Phyllis Lydia Gordon** 17. Father's Name (First, Middle, Last) ပ Robert Lee Culler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2498 Five Shillings Road, Frederick, Maryland 21701 Deborah Korrell Culler / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) September 27 1 Burial 2 K Cremation 3 Removal from State Smithsburg Crematory Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Cardio Vas enla Immediate Cause (Final Physician/ D'e o (or as a consequence of) resulting in death) Medical **Examiner** Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to for as a conseductice on: Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): the burial attending physician Division of Vital Records, P.O. Box 68760 use as IF FEMALE s, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably Unknown plnous peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? certificate Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death

Natural

Accident 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director, A Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/ox investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете (Check only one 29b. Signa License numbe cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete 300 West Ninth Street, Frederick, Maryland 21701 Robert L. Kaufmann, M. 31. Date filed (Month, Day, Year) SEP 2 9 2011 32. Registraris Signature State

Registrar

11-06822 Danielle Marie Cooper Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20

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	State of Maryland	Department of He	ealth and Mer	ntal Hygiene

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yi-ulcai Examin	G	Danielle Marie Cooper 4a. Facility Name (if not institution, give street and num	per)	4b. City, Tow	vn, or Location of Death		4c. County of Death	
		Prince George's Hospital		Cheverl			Prince George	
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h the Mar 3a or 28a	Director	12704 Midwood Lane			20715		U.S.A.	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f abo or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed For 1 Yes 3 Widowed 4 Divorced If Yes, Give Year	dent Ever in U.S. ces? 2 X _{No}		of Hispanic Origin? (Sp Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	nite
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D 21 should and Me 7 is man	٩	19a. Informant's Name/Relationship (Type, Print) John S. Cooper Sr. — Fath	100		(Street and Number or F wood Lane,			, Zip Code)
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Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If item 27 is re injury or other traumatic	1	21. Signature of Funeral Service Licens e	000	22. Name and Ad	dress of Facility Be	eall Funer	al Home	
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/Medical		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition)	3					Between Onset and Death
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Hospit 24 hour Funer tely fill	2	29a. Certifier 1 CertifyIng Physician: To the best	of my knowledge, de			d due to the cause(s	s) and manner as stat	ed.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of and manner sta					d place, and due to the	
60	≥	29b. Signature and title of certifier	A-		icense number O.C.M.E.		September 10, 2	
30. Name/and address of person who completed cause of death (Item 23a)								
		Melissa Brassell, MD Assistant Med	ical Examiner	900 W. Baltimo	ore Street, Baltimo	ore, MD 21223		
Sta Regist	ate	31. Date filed (Month Day Yar) 4 2011 32. By	istrar's Signature	park				

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State Registrar

Raman Tuli, M.D. 10810 Darnestown Rd, Suite #0202, Gaitherburg, Md 20878 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 1 6 2011

30. Name and address of pers why completed cause of deal of tem 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - Month Physician/ 9:41 PM eptember 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hyattsville homas Georges 5. Social Security Number If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
September 27, 1951 District of Columbia If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔼 F Hours Min. 9 Months 578-72-7561 Yrs. **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0783 15H 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+))omestic Homemaker Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ewis 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2216 Brightseat Rd. Apt #201 Landover, mD. 20785 daughter ampbell)uanita 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from State September 19211 Riverdale, mD. verdale 4 ☐ Donation 5 ☐ Other (Specify) (compry) Signature of Funeral Service Licensee 22. Name and Address of Facility 56 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Esquentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (of as a consequenc the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ate has been signed by the atte page 2 should be detached for a in the past 12 months? Month Pregnant at time of death Yes a No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 N 1 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Of D. Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ti 29d. Date signed (Month, Day, Year) 006368 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 University Blud. #208

State Registrar 31. Date filed (Month, Day, Yea SEP 1 5 2011

Hyatsville, mD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sept ELSON DUVALL PM BOURNE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Months Days Hours Min 219-18-7149 Director 86 arvland Usual Residence of Decedent at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f sh notified a MD. Harford 1 Tyes 2 No White Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 4216 Harford Creamery Road 21161 United States items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, "natural", or ite Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Specify 3 Divorced Specify. Completed White WW II the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) of Head Animal Control Baltimore County traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Benjamin Alfred Duvall Edith Anna Wisotzkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia C. Scarlett 4216 (Dau. Harford Creamery Rd. other t White Hall. 20a. Method of Disposition
1
Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. 4 ☐ Donation 5 ☐ Other (Specify) 2011 Cremation Hampstead, Maryland re of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ disease or condition resulting in death) minute Medical Due to (or a) a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the · as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No ò Day Pregnant at time of death Month Year been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy performed?

Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **N**0 1 🗌 Yes Other: 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after dea. 1 Natural 5 Pending ☐ Accident ☐ Suicide 1 🗌 Yes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

show

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Page 1 and 2 should be filed within 72 hours after death

Il Hygiene.

and Mental Fis marked o

item 27 i

(Jo)

and

attending physician

has

Baltimore, Maryland 21215-0036

10 en

24 hours a

within 2 To the F

Medical

29a. Certifier

Date filed (Month, Day, Year)

Registrar

State

29b. Signature and title of certifier

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 208

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER Day 26 2011 Physician/ 9:52 CONSTANCE ELAINE DRURY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours eb. 11 . Year 946 1 □ M 2 □XF Marvland 65 219-46-1220 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Frederick Maryland Frederick XX Yes 2 No 10f. Zip Code 21701 10g. Citizen of What Country? U.S.A. 10e. Street and Number 360 Prospect Blvd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) Factory Worker Manufacturing Be 18. Mother's Name (First, Middle, Maiden Surname)
Geraldine Jane Stitely 17. Father's Name (First, Middle, Last) Alvie Edward Shelton ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 360 Prospect Blvd., Frederick, MD 21701 Austin F. Drury, husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Smithsburg Crematory Sept. 30, 2011 Smithsburg, MD 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ntere of Funeral Servic 21. Signa ²ඇළළුණ්ජ්ජ්ජ්ජ්ජ්ජ්රවේ PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ cardiogenic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Dicketes burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of resulting in death) Last nding physician use as the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown the ped 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ End Stage Renel Distorte 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No ospital or Attending Physician: The la hours after death.

uneral Director: After this certificate ha dilled in by the funeral director, page? death? 1 🗌 Yes 2 🗖 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 X No 2 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28d Describe how injury occurred Certificate: 5 Pending 1 X Natural ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 29b. Signature and title of certifie 29c. License number Marily Lillan

State Registrar

Bur

31. Date filed (Month, Day, Year) 32. Registrar's Signature SFP 2 9 2011 Several S. Apar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marius J. Nefliv, M.D., 400 West Seventh Street, Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sept. 2011 Miriam Prather Deptula 7:00 a.m.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death St. Mary's 41406 Breton Beach Road Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Min. (Month, Day, Yea 0/05/192 Months Davs Hours Country) **Director** 455-26-1017 88 rizona Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 1 🗆 Yes 2 🄀 No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20650 41406 Breton Beach Road 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2

No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 Xio Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) event, the Real Estate 12 Real Estate Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nellie Cox Walter Julian Prather 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41406 Breton Beach Road Leonardtown, MD 20650 Valerie Deptula / Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Tremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-21-2011 Charlotte Hall, MD Brinsfield-Echols of Puneral Servic Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. any Brinsfield M00052 22955 Hollywood Road, Leonardtown, MD Jr. 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ rolempholytu leukemin acuti disease or condition resulting in death) wes. Medical Examiner Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a co fraterial that initiated events resulting in death) Last Due to or as a consequence of) attending physician a for use as the burial-Physician/Medical yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

☐ Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery ed by the atter in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy certificate ha performed death? 2 🗷 1 Yes Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 2 No 1 Yes 4 Nursing Home 5 X Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔀 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/19/11 RO63357 una Kussell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40900 MD. 20650 Muchants Lane Leonard town. Kussell 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ **JAMES** DOTSON eptembe aM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death **Examiner** Plata a If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 😿 M 2 🗆 F Days Hours Min (Month, Day, Year) 6-24-1934 Country) 407-40-4823 77 Yrs **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES 1 X Yes 2 ☐ No LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6526 ELLENWOOD DRIVE 20646 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify:WHITE 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) DOTSON ELEC.CO. ELECTRICAL CONTRACTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 J. SCOTT DOTSON MYRTLE DAUGHERTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVELYN DOTSON-SPOUSE P.O.BOX 95 LA PLATA, MD. 20646 Baltimoré, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1

 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM.GARDENS 9-29-11 WALDORF, MD M00479 21. Signature of Funeral Service Licenses 22. Name and Address of Facility RAYMOND FUNERAL S SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one couse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PAUL Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate has ral director, page 2 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) ᇛ 1 🗌 Yes 2 No 1 X Inpatient 2 - ER/Outpatient 3 - DOA funeral . Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) Natural ☐ Accident 5 Pending work?
1 Yes 2 No thin 24 hours after death.

the Funeral Director; Af
impleted filled in by the fu Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a, Certifie Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of the best of the cause(s) and manner as stated. (Check only one 29b. Signative and title of certifier 29c. Licer cause of death (Item 23a) (Type, Print address of pers

State Registrar 31. Date filed (Month, Pay Year

, Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia Medic		DONAL	D MYRO	N FARNSWOR	TH						SEPTEMBER 12 201			2011	2:45	P M
Examin		112 SOMERSET ROAD						EVEN	Location of	E				of Death		
Funeral Director	- 1										9. Birth	place (State	or Foreign			
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Maryland 28a-f show otified at	irect	MD	QUEEN	ANNE'S		STEVENS	SVILLI	E _							1 □ Ye	s 2 X No
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Marri 3 Widowed		If Voc Cive	ces? 2 No		Vas Decede Yes, speci				ecify Yes or No- Rican, etc.)			ck, White,	can Indian, etc.	
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permit. P Departme Importar any injur once.		21. Signature of Fur			2	F]	. Name and	S. H	ss of Facilit	Ty VBEII	N & NEW	MAM	FUNI	ERAL		P.A.
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Physician/		Immediate Cause (disease or condition	Final	only one cause on eac	LUV	06- C	ANC	ER							Interval Be Onset and	Death S
Medical Examiner		resulting in death)		Due to (e	or as a consec	quence of):										
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu	by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 i 1 Yes 2 [9 Unknown	months? 1									-	Year			
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e Hospita 24 hours e Funera bleted fille	Medical	(Check 2		g Physician: To the be Examiner: On the bas g Nurse Practioner:	s of examination	on and/or invest	tigation, in r	ny opinio	on, death o	ccurred a	t the time, date	and place	e, and du	ue to the c	ause(s) and m	anner stated.
To th within To th comp	2		title of ceruite		00	\			e number	24					Day, Year)	
6/1/3		W.Dal	ess of person	who completed caus	of death (Iter	m 23a) (Type, F	Print)	1h	ALL	IM.	210	A	W_{N}	MOR	15 (1)	12140
Stat Registra		31. Date filed (Mont	h, Day, Year) EP 15	2011	gistrar's Signa	ature		AN L	V		- (0	/ 10	~101	MUU	~ ~~	V 11-

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10f per flagging 9-29-11 vr. State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ September 23, 2011 Vincent D. Greco 10:20A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cherry Lane Nursing Center Prince George's Laurel i. Social Security Number 212-24-3938 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Nov. 11, 12930 1 √x M 2 □ F Months Days Hours 80 **Director** Mary Vand Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a, State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director 10d. Inside City Limits Maryland Howard Jessup 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 20794 10g. Citizen of What Country? United States 9950 Guilford Road, #306 per nit. Page 1 and 2 should be filed within 72 hours after death w Derartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musone. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White Yes Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname)
Dorothy Dodd ပ Nuncy Greco 19a. Informant's Name/Relationship (Type, Print) 19b, Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12-122nd Street Ocean City, Maryland 21843 Sheila A. Fair -daughter 20a. Method of Disposition 1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematory 9/23/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Tuneral Service Li ensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Part 1. Exert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Over 1 year Physician/ disease or condition resulting in death) Cirrhosis of the Liver Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death
Unknown Month Dav Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate 1 ☐ Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ၉ Other: 2 XNo within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) September 23, 2011 D24721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed A. Sadiq, M.D. 14333 Laurel Bowie Road, #208 Laurel, Maryland 20708 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 1 - State AMEND#24a per Diener's Autopsy Services: 9/16/11: BWL MOD Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPI 3.25P M ELIOT JOLDMAN 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Burtonsville Sanctuary at Holy Cross Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F 220-60-0580 60 washington. **Director** Usual Residence of Decedent show 10b. County 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 20901 U.S.A. 10107 Portland Place 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Mental Hygiene. marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jack Goldman Sophie Dubb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1808 Cullen Drive, Silver Spring, Maryland 20905 Karla Raymond - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 🛛 Cremation 3 🗌 Removal from State Donation 5 Other (Specify) Lincoln Crematory 09/21/2011 Brentwood. Maryland Signature of Faneral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death THORACK ANEURUSM OF Physician/ OMPLICATIONS Medical resulting in death) Due to (or as a consequence of): Examiner NON TRAUMATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-trapeit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death
Unknown Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes -2 25. Was case referred to medical examiner? To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c, License number 29d. Date signed (Month, Day, Year) 128595 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith 2835 31. Date filed (Month, Day, Year) Registrar's Signature 15 2011 SEP Registrar

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 00:50 AM Georgy Galin Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Yoh, 26) 1 XM 2 □ Months Days Min **Director** 217-77-9729 Russia 73 Feb. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No Maryland Derwood Montgomery ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 19037 Raines Drive 20855 Russia 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner ò þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Russia Academy of College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Geologist Science Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Galin Yoseph Anna Berezneva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olga Galin/Daughter 19037 Raines Drive, Derwood, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 9/16/2011 | Alexandria, Virginia dure of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home East Deer Park Dr., Gaithersburg, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) YPUTS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infinitelate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) P The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Pregnant at time of death 1 Yes 2 L 9 Unknown ed by the a g 🗌 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: autopsy performed? Yes 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi

Completed filled in by the funeral is 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injun 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GROVE RD ROCKVILLE HD 15221 State 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Н. Gregory Eugene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 XM 2 □ F 215-66-9723 56 1955 Tennessee Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Hyattsville MD PG 1 X Yes 2 □ No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20785 USA 6700 Belcrest Rd. #620 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 No 1976—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 1982 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Marian Louise Scott Thomas Montgomery Gregory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Gregory/Brother 5928 3rd St. NW Washington DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Riverdale, MD Riverdale Pk Crem. 9-15-2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II FH Laborios 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Organ disease or condition Medical resulting in death) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence or, attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown a | Linknown is been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Grastro intestinal Bleed Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hebertorenal Syndrame 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed 1 ☐ Yes 2 ☑ No Yes 2 No **Division of Vital** 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No ဂ္ဂ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours and war.

To the Funeral Director: After the completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending | 24 hours after death. 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signatur# and title of certifier D0083703 TEOD CARROLL AVEIVUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUDMA PARK, MO SMBYASACH UBR 32. Registra's Signature 31. Date filed (Month, Day, Year)
SEP 1 6 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 11, 2011 5:17 Alphonso A. Gorham Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Year) 953 Months Days July 29, Director 245-90-4019 58 Yrs North Carolina Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 🔀 Yes 2 🗌 No Temple Hills Maryland Prince George's 10e. Street and Number items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 2900 Oxon Park Street 20748 United States permit. Page 1 and 2 should be filed within 72 hours after death 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 H No Specify. "natural", Specify: Allica American Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Federal Bureau Electronic Operation Technician Elementary/Seconday (0-12) College (1-4 or 5+) Of Investigation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cariner Toppings Walter Gorham Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748Department of Health ar Important: If item 27 is any injury or other trace Marjorie B. Gorham - Wife 2900 Oxon Park Street Temple Hills, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State September 17, 2011 4 Donation 5 Other (Specify) Ressurection Clinton, Maryland Signature of Functial Service Licensee 22. Name and Address of Facility $Stewart\ Funeral\ Home,\ Inc.$ 10 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician Acuto Atheroscience cardiovascular disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner th perten am Sequentially list conditions. cause. (Disease or linjury Due to (or as a consequence of, Exami The law requires that the death certificate be executed physician and s the burial-trans machiams abeten that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the attending plants to the design the second the second to the second the se IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ been signed by the atte should be detached for in the past 12 months? Pregnant at time of death Month Day 2 No 1 Yes 2 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by marbia obeali 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ➤ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an I or Attending Physician: The law after death.
Director: After this certificate has autopsy performed? Yes 2 N death? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 \ \ ျှ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) pleted filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work?
1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) David K MALA D50689 09/13/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Syrvatts Read- Chiron MD

State Registrar ANILKMAMASON

SULTERNA MENTIONED AUSPITED

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month Medical Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical Center Anne Avundel MD 2140 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 Days Director 4/6/1928 Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Md Anne Arundel Deale 1 X Yes 2 □ No 10e. Street and Number ō 10f. Zip Code items 23a or ner must be r 10g. Citizen of What Country? Funeral 609 Park Place 20751 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or ite the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 X Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8 Computer Operator Private injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pasquale Yaendole Susie Zullo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Harold Meador/Son 1135 Sailfish Court Churchtown, Md. 20733 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 4 Donation 5 Other (Specify) 9/15/2011 Brentwood, MD. 21. Signature of Funeral Ser 22. Name and Address of Facility Fort Lincoln Funeral Home Dreta nances 3401 Bladensburg Rd 20722 Brentwood, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine quence of Due to (or as a cons Cause (Disease or linjury that initiated events resulting in death) Last burial-transi and Due to (or as a cons physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day 1 Yes 2 No Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Cunknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed Yes 2 death? teus ou this certificate 2 No 1 Yes **Division of Vital** 25. Was case re a red to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 No 1 Yes Other: ပ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) n 24 hours after death.

e Funeral Director: After the older of filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 10 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one on who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Se b Melvin Victor Harris 2011 1903 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General HOSDITAL Howard. Columbia Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Days 534-26-9499 81 Nov. 15 Day 929 Washington Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Burtonsville Montgomery 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 4309 Sandy Spring Road 20866 United States death 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No
If Yes, Give 1955–19 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give 1955–1956 Year or Dates. 1 ☐ Yes 2 ☐ No Specify: "natural" Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Fire Protection Engineer Fire other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harry Harris Mary Saylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other traur. Margaret Jean Harris -wife 4309 Šandy Spring Road Burtonsville, Maryland 20866 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Maryland Veterans Cemetery 9/26/2011 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bohald V: Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Pheumonia disease or condition resulting in death) MS Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause (Disease or iinjury Due to (or as a consequence of): ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Melli tus 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown lension: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy pade perform certificate 1 Yes 2 N : After this certifications and director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No Other: ည 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year. 1 V atural within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 042892

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State Registrar Lanc

Columbia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chuidian

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Day Physician/ 1810 p M 2011 John Francis Hoban, Sr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frostburg Frostburg Village Nursing Home Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) 6 05 1925 Mary land Days 86 **Director** 219-14-6078 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if fiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 I No Frostburg MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21532 1 Kaylor Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Y No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) University Boiler Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Hase Hoban John Hoban 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19324 Upper Consol Rd Frostburg, MD 21532 Kevin Hoban 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-29-2011 Frostburg MD <u>Frostburg Mem Park</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, Sow 253 moc547 60 W. Main St., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I , page 2 s performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 N **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) (2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the tune 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Numbe Pranticions To the best of my knowledge, death presented the time, date and place, and due to the neusels) and menner as state 29b. Signature and title of certifier 29c. License number D26907 SEPTEMBER 27 2011 Thoulkn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Sidhu MD 925 Bishop Walsh Rd Cumberland MD 21502 laclit 31. Date filed (Month, Day, Year) SEP 2 9 2011 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 24, Herring 2011 23:00 P M Shirley . Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death E1kton Cecil Union Hospital 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Days Hours Month, Day, Year) September 3, Country) Indiana **Director** 311-30-1271 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 United States 104 Normira Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cecil County Elementary/Seconday (0-12) College (1-4 or 5+) Fire Headquarters Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Allen Martin Robey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald C. Herring/Husband 104 Normira Avenue, Elkton, MD 21921 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 28. 4 Donation 5 Other (Specify) Gilpin Manor Memorial Park 2011 Elkton, Maryland 22. Name and Address of Facility Hicks Home for Funerals, P.A. Signa re of Funeral Service Licensee 103 W. Stockton St., Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onse) and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Year Month Day ate has been signed by the a page 2 should be detached f 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Won Small Cell Ca 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Jackder 5 MM 9.26.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S Saddew MD 26 A, E High ST, Elector MD21921 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ atenheu Ellen Hailes Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Lanham Prince Georges Doctors Community Hospital If Under Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 😾 F Months Days Hours Min (Month, Day 98 Yrs 577-86-8031 **Director** Carolina 1913 South Mar. Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A Washington DC 1X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 20011 United States 542 Peabody Street, NW items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Completed 3 X Widowed 4 Divorced American injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Meaone. Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Anthony Diggs Elizabeth unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Lacy / daughter 6303 Taylor Road, Riverdale Park, MD 20737 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. 9/16/2011 Suitland, Maryland 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee 7400 Georgia Avenue, NW, Washington DC 20012 Indle! ho 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as Examiner eumon. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine requires that the death certificate be executed Cause (Disease or iinjury sician and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an Hospital or Attending Physician: The law certificate has page 2 autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No မ 1 Minpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending work? within 24 hours after death. To the Funeral Director: A 2 🗆 No M Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Completed filled in by 4 Homicide determined Medical 29a, Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar 29b. Signature and title of certifier

nth, Day,

1 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yene

Registrar's Signature

Doctors

29c. License number

D0068976

Community Hosp:

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 24a per med cert 1920 1075/11 dk
State of Maryland / Department of Health and Mental Hygiene For State Registraramended item 17 wchd-te-9/14 Pritificate of Death Reg. No. 0 31156 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month C Physician/ 6600 Hurdl 10bert Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 20115bur Wicomico Heninsula Regional medicul center Date of Birth (Month, Day, Year) **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months 230-18-0002 Director 1 **№** M 2 □ F 89 12-14-1921 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director be notified 1 XYes 2 ☐ No Chincoteague Hccomac ō 10e. Street and Number 10g. Citizen of What Country? 23a Funeral Blud 76 23336 Maddox U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian "natural", or iter idical Examiner Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates. 1943-1945 Health and Mental Hygiene. tem 27 is marked other than "natul ther traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NASA Master Mechanic Be 17. Father's Name (First, Middle, Last) Bonard S. Hurdle 18. Mother's Name (First, Middle, Maiden Surname) ည heynold e 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 i. Hurdle ٥٤ item 2 other t Maddo 20a. Method of Disposition 20c. Location - City of Town, State 20b. Place of Disposition (Name of Date Department of Important: If it any injury or o cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-15-2011 4 Donation 5 Other (Specify) Temperance ville, UA Taylor Cemetery Chincoteague, VA 23336 nc. 6327 Church St. 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Botto Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** bequestinary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ō in the past 12 months? Day Year Pregnant at time of death signed by the at d be detached fo 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an certificate has prior to completion of cause of death? autopsy performe 2 No Yes 2 X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 **N**0 Hospital Other: မ 1 Yes 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) pletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death. 1 Natural 5 Pending injury 1 🗌 Yes 2 🗌 No Accident Investigation M 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29c. License number ss of person who completed cause of death (Item 23a) (Type, Print) ame and end IVA Berg mueller State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 11, 2011 2256 ROSA JACKSON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE 'S SOUTHERN MARYLAND HOSPITAL CENTER CLINTON Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🕱 Hours (Month, Day, AUGUST Country) 247-82-2563 66 Director 17,1945 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1X Yes 2 ☐ No PRINCE GEORGE'S CLINTON 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 6920 CRAFTON LANE 20735 UNITED STATES or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Completed by 1 Never Married 2 X Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 🗆 Widowed 4 🗆 Divorced Specify: BLACK Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12TH FEDERAL GOVERNMENT FINANCIAL ANALYST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LEVERN ARTHUR ROSA LEE YATES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6920 CRAFTON LANE, CLINTON, MD 20735 Baltimore, JIMMIE JACKSON/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place RESURRECTION CEMETERY 09/16/2011 CLINTON, MARYLAND 4 Donation 5 Other (Specific Signouse of Funeral Service Lice 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 5538 MARLBORO PIKE, FORESTVILLE, MD 20746 Part 1. Enter the disease, of coshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine **To the Hospital or Attending Physician:** The law requires that the death certificate be executed and Due to (or s a consequence of Station Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 G P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🛣 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certain 7801 old Branes Ale 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ P_{M} Willie Mae Johnson N9 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's <u>Hyattsville</u> Thomas Moore Nursing Home If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) **Funeral** 1 🗆 M 2 🔀 F Hours (Month, Day, Yea 08/08/193 577-42-7005 79 Director Usual Residence of Decedent 28a-f shov 10a, State 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s dical Examiner must be notified 1 X Yes 2 No MD Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 United States 1914 Palmer Park Road death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private 11th Housewife Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental I Important: If Item 27 is marked c any injuy or other traumatic eve onee. ည Delta Carter Beatrice Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1914 Palmer Park Road, Landover, Maryland 20785 Diane Freeman/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Brentwood, Maryland 09/16/2011 4 ☐ Donation 5 ☐ Other (Specify) ncoln Cemetery 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service License 5538 Marlboro Pike, Forestville, MD 20746 ann 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Artemoscherone CAndiovascular Physician/ disease or condition eaus Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for an a connection of or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No for Day Year 5 Other (specify) Pregnant at time of death Yes Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease Conormy Antery By Parsyrup should be 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown End Stage Penal Disease / Hemodialysis/Diabets 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has Perphoral arterial Disense left Below Ever amounting performed? Yes 22 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Yes 2 🔀 No ၉ wutiin 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral directors and the funeral directors. 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. . Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Quelensbury Rd Hyuttsville MA 2008 MD State

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the but	~ I	1 Live Birth 2 Fetal death 3 Ectopic pregnancy									Date of deliv Month		
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	ł	30. Name and addre	ess of person who	completed cause o	f death (Iter	7300 \	Print) Laure	1 Regiona	Il Hospit	al, E	merge MD	ncy Dept.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 20/1 Gladys Irene Kissee Medical Feeility Name (if not institution, give street and num Examiner ocation of Death 4c. County of Death APLATA ENTER harles MEDICAL Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F 577-24-6990 92 $\mathbf{J}_{\mathbf{u}}^{M\mathbf{n}^{th}, D\mathbf{a}^{y}}, \mathbf{J}_{\mathbf{v}}^{Year} \mathbf{1919}$ Mary land Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director 10d. Inside City Limits Maryland 1 Yes 2 X No Charles White Plains 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral 4757 Londonberry Lane 20695 United States or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important. If item 27 is marked any injury or other traumatic ev is marked John A. Maddox pe Mary L. Adams Page 1 and 2 should I nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Oliver/Sister 39767 Hiawatha Circle, Mechanicsville, MD 20659 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🛚 😾 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Greenwood Cemetery 09/20/2011 New Orleans, LA 22. Name and Address of Facility $Brinsfield-Echols\ F.H.,\ P.A.,$ Signature of Euneral Service License M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final au Priysician/ disease or condition Medical resulting in death) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown ed by the a 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖳 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has e 2 autopsy r this certificate ha aral director, page 2 performed? Yes 2 2 🗌 No 1 🗌 Yes Be (funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

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completed file 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pertifying Nyrise/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only g 29b. Sign 29c. License number 29d. Date sigged (Month, Day, Year) ed cause of death (Item 23a) (Type, Print)

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Edward James Lennon, Jr. September 17, 2011 8:10 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 44049 Fieldstone Way California St. Mary's 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 3, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Min. 1 💢 M 2 🗆 F Hours New York **Director** 083-34-7110 70 July 1941 Usual Residence of Decedent 28a-f shov 10a State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎇 No Maryland St. Mary's California 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 44049 Fieldstone Way 20619 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 72 than Elementary/Seconday (0-12) College (1-4 or 5+) Project Manager Construction other Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever မ Edward James Lennon and 2 should be Health and Me Rose Farley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Crystal Lennon/Wife <u>44049 Fieldstone Way, California, MD 20619</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I Important; If it any injury or of once. ᇹ 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/22/2011 Trinity Mem.Gardens Waldorf, MD Signature of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 exility M00817 2 a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Small cell 4 r 10 months disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Sequentially list continues, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death
Unknown 2 No 1 ☐ Yes 2 L 9 ☐ Unknown the been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy perform death? 2 🗌 No 1 Yes Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) (è 1 Yes 2. No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 Natural 5 Pending work? 1 Yes 2 🗌 No Accident Investigation 6 Could not be filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) edical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier eted 2 | Medical Examiner: On the basis or examination and/or investigation, it my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 50686 9/19/2011 15)eme 2341 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Three

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signa

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LARRY LEE LOBAUGH SEPT 23 , 2011 ea 12:40P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8800 LOWELL ROAD CHARLES POMFRET If Under 1 Year | If Under 24 Hrs Funeral Social Security Number 6 Sex Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Hours 4-29-1944 WASH., D.C. Director 217-44-4072 67 Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD. CHARLES POMFRET 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 8800 LOWELL ROAD 20675 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married þ 1 X Yes 2 No USAF If Yes, Give 1963-67 Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: WHITE Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) CENTURY OFFICE Elementary/Seconday (0-12) College (1-4 or 5+) OFFICE FURNITURE REPAIRMAN SERVICES 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HARRY TRUMAN LOBAUGH, SR. ARLINE PEARL PYLES and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE LOBAUGH-SPOUSE 8800 LOWELL RD. POMFRET, MD. 20675 1 and 2 s of Health item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1X Burial 2 Cremation 3 Removal from State WASHINGTON NATIONAL 9-28-11 SUITLAND, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Aneral Service Licens M00479 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ance Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t page 2 s autopsy performe death? 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2. FNO 4
Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After the funeral by the funeral Natural Accident Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#12, 18, 19b State per FH. 9/13/2011 Registrar AACO HEALTH DEPT Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Harold Norman Milburn Month Day September 10, 2011 Medical 2:18 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 - F Hours 5/12/1928 220-22-3274 83 Maryland Director Usual Residence of Decedent 28a-f show 10a. State 10b. County r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Anne Arundel Maryland 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21401 123 Gibson Road be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 45-49 Black, White, etc. þ 1 Never Married 2 Married 1 x Yes 2 No 45— If Yes, Give 47—50 Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Technician US Navy Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Ruth Milburn Thompson Fred Milburn : Page 1 and 2 should by tment of Health and Mer tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number City or Town, State, Zip Gode)
2018 Hanson Overlook, Annapolis, MD 21401
018 John Harson Overlook, Arrapolis, MD 21401 Dennis Lowman - Nephew 2018 John Hanson Overlook. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory, or other place).
Hillcrest Mem Gardens 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 9/15/11 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Descript at time of death 5 Other (specify) use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ģ Month Day Year be detached P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 24 hours after deatn.

Funeral Director: After this certificate heted filled in by the funeral director, pag. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 2 100 ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MY 139 010 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. 10, Day 2011 Year Morch Winifred 11:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1602 Belvedere Blvd. Silver Spring Montgomery Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 1 M 2 X F Oct. 26, 1923 87 115-22-1989 Virgin Islands **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1602 Belvedere Blvd. 20902 USA 12. Was Decedent Ever in U.S. Armed Forces?v 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black "natural", 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Macy's Department Store Sales Representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ၉ William George Lewis Edith Rose Monsanto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Samuel Morch/Husband 1602 Belvedere Blvd., Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Sept. 18, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Michard Litetes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or I that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ctopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate; 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Completed filled in by the funeral process. 1 X Natural 5 Pending injury Division 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State

Registrar

of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Amit Rajvanshi, MD

1 5 2011

31. Date filed (Month, Day, Year)

D0037891

121 Congressional Lane, #400, Rockville, MD 20852

Sept. 13, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 25, per me, g922 12-29-11 sm
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Howard Jackson Moore, Jr. 2011 September 16 07:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2 □ F Days Hours Min Director 216-94-6291 44 01/16/1967 Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Hollywood Maryland St. Mary's or 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 43310 St. John's Road 20636 S 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Parts Specialist Plumbing/Heating 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Howard Jackson Sharon Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Catherine A. Moore/Wife 43310 St. JOhn's Road, Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gardens 09/22/2011 Waldorf, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CADELL disease or condition resulting in death) Medical Examiner Wolemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (as a consequence of): AL EXAMINER amenia Cause (Disease or linjury that initiated events resulting in death) Last and or as a consequence of signed by the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy yes 2 No this certificate 2 🗆 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Hospital Other: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director; After th filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined within 24 hours a

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completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Praction of To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29d. Date signed (Month, Day, Year, 12011 06047 use of death (Item 23a) (Type, Print) 30. Name and address of Mais 0

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State Registrar

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			Registrar 1. Decedent's Name (First, Middle, Las	t)		007	ancare or L	- Catir	2. Date of De	Reg. No. 3			
	Physicia Medic		Emma Katherine	Miller					Septe	ember 20,2011 12:45a.			
~	Examin		4a. Facility Name (if not institution, give				4b. City, Town, o		eath	4c. County of Death			
	Andrew Co.		St. Mary's Hospi 5. Social Security Number 6. Se		- (In . wo . lo	at hirthday	Leona If Under 1 Year	rdtown	Hrs. 8. Date of Bi		St. Mar	y'S nplace (State or Foreign	
F	Funeral Director		238–96–7562 Usual Residence of Decedent	M 2 🛣 F 7. Age	e (in yrs. ia 9	st birthday) 7 Yrs.	Months Days		Min. (Month, Day 12/02)	71913	Pen	ntry) nsylvania	
	fand show dat	tor	10a. State 10b. County			, Town or Lo						10d. Inside City Limits	
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	with the	Funeral Director	10e. Street and Number 43380 Drumcliff	Road			10f. Zip Code 20	636			zen of What Cou		
	items items	Fun	11. Marital Status	12. Was Decedent E Armed Forces?_	ver in U.S	i. 13. V	Vas Decedent of H	lispanic Origin'	? (Specify Yes or No- uerto Rican, etc.)		14. Race - Ameri Black, White		
21215-0036	ırs after o ural", or I Examir	ted by	1 ☐ Never Married 2 ☐ Married 3 【X Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	Mo		Yes 2 No				hite		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day ICHOUS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 909 Malvern Hill Drive Davidsonville Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 10 M 2 □ F Months Days Hours Min. 536-42-8018 64 129T391946 Country) OR Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ms 23a or 28a-f s must be notified MD Anne Arundel Davidsonville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 909 Malvern Hill Drive 21035 USA ral", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc ^{2 No} Vietnam Completed by 1 Never Married 2X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced If Yes, Give "natural" Year or Dates. item 27 is marked other than "natur other traumatic event, the Medical. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Accountant Elementary/Seconday (0-12) College (1-4 or 5+) 04 Law Firm 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ဂ္ Archie Nicholson Margaret Brumbaugh and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health item 27 909 Malvern Hill Drive Davidsonville, MD 21035 Sharon Nicholson Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Filmportant: If ite any injury or other Date 20c. Location - City or Town, State 1 Burial 2 T Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 09/12/2011 Glen Burnie, MD 22. Name and Address of Facility 851 Annapolis Road Gambrills,MD 21054 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). the burial-transit Due to (or as a consequence of): ding physician Physician/Medical that the death certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery atten 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Month Day Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to dical Be 26. Place of Death (Check only one) 1 Tes မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No hours after death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Modifical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 20 se of death (Item 23a) (Typ State 201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12, Month Krikor Nakashian September 2011 11:35 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House-Montgomery Hospice Montgomery Derwood Social Security Numbe 8. Date of Birth (Month, Day, Year) Nov. 30, 1955 9. Birthplace (State or Foreign Country)
Syria 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🖾 M 2 🗆 F Months Davs Hours Director 217-96-9957 55 Nov. Usual Residence of Decedent 28a-f show 10a. State or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2K No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 8278 Amity Circle United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced Completed White 15. Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Estimate Writer Auto Body Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) any injury or other traumatic Nakashian Matossian Marie Hagop 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Maral Nakashian/ Spouse 8278 Amity Circle, Gaithersburg, Maryland 20877 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 9/15/2011 Silver Spring, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Colon Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2 🗌 No 2**X** No 1 🗌 Yes Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: မ this c 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 K Natural 5 Pendingural ∐ Accident □ Suic To the Hospital or Attendia within 24 hours after death... To the Funeral Director: At 1 ☐ Yes 2 ☐ No Investigation Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 D 37142 September 12, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Coleman,

31. Date filed (Month, Day, Year)

SEP

6001

M.D.

15 2011

Box 68760

P.O.

Records,

Division of Vital

Muncaster Mill Road, Derwood, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | | State of Maryland / Department of Health and Mental Hydiene

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ō	Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation 4 Donation 5 Other Sp		3(0)	natory of		1_22_2011	Delmar, D	elaware		
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		Ì	30. Name and address of person v	who completed cause of d					•	-		
			Melissa Brassell, MD	Assistant Medical			more Street, Baltir	nore, MD 2122	ა 			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:15 A M Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CRESCENT IVERDALL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Month, Day, Year 06/11/1923 Davs 1 ★ M 2 🗆 F Months 227-22-9479 Director 88 vnchburg Va Usual Residence of Decedent 28a-f shov with the Maryland iral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Prince George's Upper Marlboro 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3900 Bishopmill Place U.S Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1X Yes 2 No If Yes, Give 43-46 Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify : If item 27 is marked other than "natural", or other traumatic event, the Medical Exal Black Specify: Completed 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Driver/Dept. of Human Services Federal Government Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed.
Department of Health and Mental Hilmportant: If item 27 is marked othany injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) မ Matthew Hurtt Virginia Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin H. Payne/Son 3900 Bishopmill Pl., Upper Marlboro, Md. 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Quantico Nat'l. Cem. 09/20/11 4 ☐ Donation 5 ☐ Other (Specify) Triangle, Va. 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of. physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not repulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably Completed Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes __ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 2 Other: 1 🗌 Yes မ No 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral Manner of Dea h 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State, 24 hours Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. yedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only c 29b. Signat title of certifie of person who completed cause of death (Item 23a) (Type, Print) Saadia 4409 HUSAIN 31. Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

Sheikh Rasheed 09/05/11 654AM

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			State of Maryland / Department of Health and Mental Hygiene O 1 1 3											
			Registrar 1. Decedent's Name (First, Middle	Last)		Cel	incate of t	Jean	2. Date of			3. Time of Death		
	Physicia Medio	cal	Sheikh Rashee				1		Sept.	5, 2	9ay Year 1011	6:45 a ^M		
- June	Examir	er	4a. Facility Name (if not institution, St. Joseph's Me				4b. City, Town, o	r Location of		4	c. County of De	ath .more		
3	Funeral Director			6. Sex 1 □ X /1 2 □ F		yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days		24 Hrs. 8. Date of I	Day, Year)	9. B C	irthplace (State or Foreign ountry) Guyana		
	land show dat	tor	10a. State 10b. County	- 1-	10	C. City, Town or Lo	cation			10d. Inside City Limits				
	ie Mary ir 28a-i notifie	Director	NY 10e. Street and Number	I/A		Br	ooklyn 10f. Zip Code	1 40 6		1 Yes 2 □ No				
	with the s 23a c ust be	Funeral	1655 East 49t	h Street				234		10g. C	Citizen of What C	·S.A.		
36	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Marr 3 ☒Widowed 4 □ Divorced	If Yes, Giv	rces? 2 XNo e		Vas Decedent of H f Yes, specify Cuba □ Yes 2X No		gin? (Specify Yes or N , Puerto Rican, etc.)	0-	Black, Wh	ce - American Indian, ck, White, etc.		
21215-0036	hours natura dical E	Completed		Year or Da	ites.		lent's Usual Occup		ofworking	16b.	Kind of Busines			
121	within 72 giene. ner than t, the Me	Com	Elementary/Secondary (0-12)	College (1-	-4 or 5+)		Sales		or working		Pot	-ail		
nd 2	filed w tal Hygi d othe event,	To Be	17. Father's Name (First, Middle, L Sadik Jaffar	ast)			Daies		er's Name (First, Midd	,	n Surname)	,		
Maryland	should be fill and Mental 7 is marked or raumatic eve	-	19a. Informant's Name/Relationsh	in (Type Print)	-	AOL Maille	A delega a Charach			Neshaw Nazmoon ural Route Number, City or Town, State, Zip Code				
, Ma				- Daughtei	c				eet, Brook					
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1	3 D Removal from	State		natory or other plac		Date		Location - City c			
altin	mit. Pa partme portani / injury		4 ☐ Donation—5 ☐ Other (S				n Cemet	4 1	9-9-2011 Beall Fi		ong Islam I Home	nd, NY		
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garde.	Physician Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. A.	ch line. 必いし	se(ero	f	(cardiac or respiratory		iagi	Approximate Interval Between Onset and Death		
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be exwining 4 burs after death. within 24 hours after death. To the Lahourst Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outo	Birth 2 ☐ nant at tim	Fetal death 3	Ectopic pregnand Other (specify)	су			23d. Date of delivery Month Day Year			
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Division of Vital Records,	The law req ate has bee page 2 sho	Completed							24a. Wa aut pei 1 🗌 Ye	s an opsy formed?	prior to	utopsy findings available completion of cause of		
/ital	sician: certific lirector,	Be	25. Was case referred to medical examiner? Yes 2 No	Hospital:		V = 2/2	_ Oth	er:	h (Check only one)					
on of \	nding Phy ath. ; After this e funeral d	icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	28a. Date of (Mont)	Inpatient of injury h, Day, Ye	28b. Time of	28c. Injury work	y at	rsing Home 5 Re 28d. Describe			cify)		
Divisio	al or Atte s after de: Il Director ed in by th	Certificate:	3 Suicide 6 Could n 4 Homicide determine	ot be 28e. Place	of Injury - ig, etc. (S _i	At home, farm, street becify)	eet, factory, office			(Street ar		ural Route Number,		
	he Hospit iin 24 hour he Funera ipletely filla	Medical	(Check 2 X Medical Ex	aminer: On the basi	s of exami	ination and/or invest	igation, in my opinic	on, death oc	place, and due to the curred at the time, date e and place, and due to	and plac	e, and due to the	cause(s) and manner stated.		
	To With Com		29b. Signature and title of certifier	4) Dep	afe	.(29c. License	number Le 67	,	29d. Di	ate signed (Mon	th, Day, Year)		
	5		30. Name and address of person w	tello Mi	> 6	Trruble	011/110	7 Lu	thervill	4 1	Md 21	093		
	Stat Registra	-	31. Date filed (Month SEP 1 4	2011 32. B	gistrar's S	Signature 6. 4	backs		, , , , , , , , , , , , , , , , , , ,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 16 Physician/ Month 9 ど MA 05:01 RAYNOR NILLIAM JOHN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LEONARYTOWN ST. MARY'S ST-MARY'S HOSPITAL 8. Date of Birth
(Month, Day, Year)
Apr. 16, If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □**X**M 2 □ F New York 1951Director 60 116-42-7591 Usual Residence of Decedent 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked outher than "natural", or items 23a or 28a-f sho wint or other traumatic event, the Medical Examiner must be notified at ury or orther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2X No St. Mary's Lexington Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 46770 Planters Court 20653 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 XYes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Δ Senior Program Analyst Government Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Grace Coughlin John Raynor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46770 Planters Court Lexington Park MD 20653 Stephanie C. Raynor / Wife Important: If iten any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X remation 3 Removal from State 9-22-2011 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 21. Si par e man al Serv e la ense 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield Jr. 22955 Hollywood Road Leonardtown, MD M00052 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) OVERWHELHIZNG INFECTION Medical Due to (or as a consequence of) Examiner IMMUNOSUPPRESSEON Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Due to for as a consequence of Cause (Disease or linjury ESOVHUGEAL burial-trar and that initiated events Due to (or as a consequence of) attending physician Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Day Year Yes 2 ☐ No signed by the a 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown METASTATZE ESOPHAGRAL CANCER TO LUNGS 24b. Were autopsy findings available 24a. Was an CHIMMOTHERAPY GON CANCER prior to completion of cause of death? , page 2 s autopsy performe Hospital or Attending Physician; The 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner?

1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 1 X Natural 5 Pending work? 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: ,
completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) ATTEMPENG AIRSTETAN 9/16/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SRUE FOREST 20650 YOTUT LUCKOUT LEONARDTOWN RUAD

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patricia Anne Reynolds 2011 September 7:30 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4303 Conowingo Road Darlington Harford Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 26, 1947 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 M 2 X F 217-46-7452 Hours Washington, DC 64 Director Yrs Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Cecil Conowingo Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44 Crocus Court 21918 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 🕅 No 21215-0036 1 ☐ Yes 2 🗓 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) A. Frank & Son permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me College (1-4 or 5+)
Two Years Elementary/Seconday (0-12) Baltimore, Maryland Comptroller Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reuben Augustus Sanders Marjorie Poole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George K. Reynolds (Husband) 44 Crocus Court, Conowingo, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, Pennsylvania cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.A.Ferris & Co., Inc. 09/16/11 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Lic ^{22. Name and Address of Facility}
Lee A. Patterson & Son Funeral Home, P
Perryville, Maryland 21903–0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by A-Fib 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2: autopsy death? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔀 No Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) A LF funeral 27, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending of Funeral Director: Af oldered filled in by the funeral prector oldered filled in by the funeral precedular filled in by the funeral precedular funeral filled in by the funeral funeral funeral funeral funeral funeral funeral functions for the function of the function o Investigation
6 Could not be 1 Yes 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an fittle of certifier 29d. Date signed (Month, Day, Year) D0062190 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 2533 AUGUSTINE HERMAN HWY, SUITEA, CHESAPEAKECITY, MD SHAHWAWAZ KHAN

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien20Certificate of Death State
Registrar 3. Time of Death 2. Dale of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Examiner** Baltimore Randallstown Northwest Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex (Month, Day, Year) Hours **Funeral** 92 West Virginia 1 □ M 2 💢 F 1919 220-22-2360 July 13. Director 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. Count death with the Maryland event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Havre de Grace Harkord MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ò u.s.A. 21078 Funeral items 23a 415 South Market Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces? 1 Never Married 2 Married "natural", or þ 1 Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 If Yes Give 3 XWidowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Home Homemaker other t 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Congeta Addia should be file h and Mental H 7 is marked of ပ္ Fumarola other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 6638 Grand Stand Avenue, Las Vegas, ge 1 and 2 sh it of Health a Robert Rink (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State or Haure de Grace, MD Department of Important: If any injury or once. 09/20/2011 Hill Cometery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. re of Funeral Service Licensee Washington Street, Havre de Grace, tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Part 1. Enter the disease, or compli-shock, or heart failure. List only one Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in its class cause. Enter Underlying Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Month Dav in the past 12 months?

1 Yes 2 No · A.4 Pregnant at time of death the a 23e. Did tobacco use contribute to the cause of death? been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 Probably 4 Unknown 1 Yes page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate has ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be examiner? Other 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes မ 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Dea Certificate: injury work? 1 Yes 2 No Matural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) the f after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e Funeral Medical 29a. Certifier within 24 hou

To the Fune

completely fi only one) 29b. Signature and 30. Name and address of person

State

Registrar

Alicante ...

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 20 State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Da Karen Rollery 2011 2011 11:00 Pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery National Institutes of Health 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F (Month, Day, 12/21/ Country) Director 145-56-8540 1956 Usual Residence of Decedent 28a-f show 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

The street of the **Funeral Director** 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified 1 Yes 2 X No Essex Roseland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 254 Eagle Rock Ave 07068 United_States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces Completed by 1 🗌 Never Married 2 🔀 Married Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2x No Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Retail Sales <u>Private</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew Struss Carol Kastner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joseph Rollery/Husband</u> 254 Eagle Rock Ave. Roseland, injury or other New Jersey 07068 20b. Place of Disposition (Name of Gate cemetery, crematory or other place) of Cood Sheppard 09/16/2011 20a. Method of Disposition 20c. Location - City or Town, State **East Banover**, NJ 07936 permit, Page 1 a
Department of H
Important: If ite
any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🛣 Removal from State 4 Donation 5 Other (Specify) Andover, New Signature of Funeral Service Lig 22. Name and Address of Facility Pope Funeral Homes, P.A. tug -101085 5538 Marlboro Pike, Forestville, MD 20746 Part . Efter the disease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple disease or condition 4 Y (5 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): /sician a Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year 9 Unknown 1 ☐ Yes ∠ # 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Tuberculosis Pulmonary 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available certificate has b lirector, page 2 s prior to completion of cause of death? performed. 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) injury 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 66270 30. Name and address of perso, who completed cause of death (Item 23a) (Type, Print) CR Halverson 10 Center Drive, Bethesda MD 20892 MD SEP 1 5 2011 32. Registar's Si State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 10 2 Year Physician/ Medical 4a. Facility Name (if not institution. 4b. City, Town, or Location of Death County of Deat Examiner brand Conti School aun Columbis If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 5. Social Security Number **Funeral** 1 M 2 KF Hours Month, Day, Ye Dec. 8, Washington DC Yrs 1928 Director 579-36-1348 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD Howard Ellicott City 1 Yes 2 Ao 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4475 Montgomery Road Elkridge U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify. Specify: 3 XWidowed 4 ☐ Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Legal Secretary Law Firm 27 is marked other traumatic event, 1 Be Fled permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John M. O'Donnell Julia A. Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8023 Brightwood Court, Ellicott City, MD 21043 Daniel J. Slattery - Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State onation 5 U Other (Specify) 9-16-2011 Washington DC Mount Olivet Cemetery Funeral Service Lice 22. Name and Address of Facility Beall Funeral Home NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner nosus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical The law requires that the death certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No for Day Pregnant at time of death detached Unknown g Unknown P.O. signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy 1 ☐ Yes 2 ☐ No Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Tes ၉ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pendina n 24 hours after death.

e Funeral Director: After the function of the functin 2 Accident
3 Sulcide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5 Seplenker 10 2011 D30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back RIVE Mac Road Ranen Sabapath 201-109

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signature

		12		State of Maryl	and / Depa	artme					31178	
	Physicia		1. Decedent's Name (First, Middle, Last)	lingred Sie	ael			2. Date of De Septem	áth	2.28 ⁻⁴ 1	3. Time of Death 8:45 a _M	
ر ما در الموسيد	Medic Examin	er	4a. Facility Name (if not institution, give str Brighton Gardens	eet and number)			r, Town, or Location of D Chevy Ch	eath ase		ounty of Daath Mont	gomery	
	Funeral Director		000-10-1724		93 Yrs.	If Und Months	er i Year I II Under 24 Days Hours N	drs. 8. Date of Bir Min. Month, Da March	th 18,191	8 9. Births	ilace (Stata or Foreign try) New York	
	Maryland Ba-f show ntified at	irector	Usual Rasidence of Decedent 10a. State 10b. County Maryland Montgome		City, Town or Lo	W	Chevy Ch	ase			0d. Insida City Limits 1 ፟፟ Yes 2 ☐ No	
	with the	eral D	10e. Street and Number 5555 Friendship E	Blud., Room	534	10f. 2	1p Cede 20815		10g. Citize	en of What Gour U.S		
980	pern it. Page 1 and 2 should be filed within 72 hour after death with the Maryland Depresser of health and Mental Hygene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show way injury or other traumatic event, the Medical Examiner must be notified at onc.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Diverced	1 Vas 9 X Na			Nas Decedent of Hispanic Origin? (Specify Yes or f Yes, specify Cuban, Mexican, Puerto Rican, etc. Yes 2 🗷 No Specify:			14. Race - American Indian, Black, White, etc. Specify: Caucasi		
Maryland 21215-0036	led within 72 hour Hygiene. other than "natuent, the Medical	Complet	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12) 12	cation completed) College (1-4 or 5+)	(Give	kind of w O NOT u	ual Occupation ork done during most of se retired) Lesperson	working		16b. Kind of Business Industry Printing and Graphic Design		
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	and 2 show Health and tem 27 is n		19a. Informant's Name/Relationship (Type Ruth Siegel Alpera				es (Street and Number o 200d Road, S		ing,	Marylan	d 20910	
Baltimore,	Page 1 ar ent of He int 17 iter	8 3	20a. Method of Disposition 1 双 Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	mayal from State	lb. Place of Dispo cemetery, crer t. Lebar	natory of	ame of other place) Cemetery 09	Date /13/2011	l	ation = Gity or To Lphi, Mi		
Balti	pernitt. P Dep Importa any inju		21. Signature of Funeral Service Licensee	omell			and Address of Facility F New Hampshi				Home, Inc. g, MD 20904	
	Physician/ Medical Examiner	ner	23a. Part 1. Enter the diseale, or a mplic shock, or heart fallure. Net only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	eations that caused the cause on each line. Stage IV Due to (or as a con-	Prostat sequence of:			diac or respiratory â	rrest,		Approximate Interval Between Onset and Death Years	
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. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate! within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicompleted filed in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pre 1 Live Birth 2 4 4 Pregnant at time 9 Unknown	23d. Date of Month			ery Day Year				
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of V	ng Phys fter this meral di	ite: To	27. Manner of Death 1 X Natural 5 Pending	1 Inpatient : 28a. Date of injury (Month, Day, Yea			28c. Injury at work?	ng Home 5 🔲 Res 28d. Describe			//	
Division of Vital	allor Attendii s after death: Il Director: A cd in by the fu	l Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - A building, etc. (Sp	At home, farm, ŝti e <i>cify)</i>	M reet, fact	1 ☐ Yes 2 ☐ N	28f. Location	(Street and I wn, State)	Number or Rura	l Route Number,	
_	e Hospit 124 haur E Funera letech fille	Medical	(Check 2 Medical Examine	lan: To the best of my k r: On the basis of examir Practioner: To the best	ation and/or inves	stidation.	n my opinion, death occu	rred at the time, date	and place, a	and due to the ca	use(s) and manner stated	
	within North	2	29b. Signature and title of certifler		MD		9c. License number		29d. Date	signed (Month,		
			30. Name and address of person who con Robert Gerard, M.1	npleted cause of death	rest Gle	en Ro	ad, Silver					
	Sta Registr		31. Date flied (Month, Day, Year) SFP 15 201	32 Régistrar's S	ignature 4	who	<i>,</i>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Physician/ Month 7:10A M STAMNOS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MARYS Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year 07/03/192 Hours 1 🗓 M 2 □ F Yrs. Director 179-14-9943 87 <u>Pennsylvania</u> Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🕅 No Charlotte Hall Maryland | St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20622 29449 Charlotte Hall Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 🔀 No Specify: Specify: "natural", 3 XWidowed 4 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) <u>Aviation Electrician</u> U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Christina Janakis Charles Stamnos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21381 Carmen Woods Drive, Lexington Park, MD 20653 Christina Mangrum/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State George's Cemetery 09/20/2011 4 ☐ Donation 5 ☐ Other (Specify) Valley Lee, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Br brinsfield, 22955 Hollywood Road, Leonardtown, MD M00052 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Filysiciai) disease or condition resulting in death) Medical Due to (or as a consequence of Examine Esquantially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be 2 No 3 □ Probably 4 □ Unknown 1 Yes 24 hours after death.

Funeral Director: After this certificate has been 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? performe 1 🗆 Yes 2 🗆 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 **N**0 ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Watural work? 5 Pending 2 **N**o Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier My ical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner To the best of my line within 2 To the I unily oin death occurred at the time date and plane, and dies to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla	•	artment of F tificate of D			giene Reg. No.	011	31180		
ı	Physicia		1. Decedent's Name (First, Middle, La	st) Tammy Jean S	hook			2. Date of De Month Septeml	Dav	3, 2 ^{Year} 11	3. Time of Death 6:30 AM		
	Medic Examin		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Death		4c. County of Death				
-			43803 Mustang Cou				11ywood		St. Mary's				
	Funeral Director		217-78-5233	7. Age (In yrs	: last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 06/05/	rth 9. Birthplace (State or Foreign Country) 1959 Maryland				
	nd how at		Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or Lo	cation			_		10d. Inside City Limits		
	arylar ta-f sl	Director	Manazaland Ct M	anula		u ₀ 11	ywood				1 ☐ Yes 23 € No		
	or 28 or 28 e not	ä	Maryland St. M 10e. Street and Number	ary's [10f. Zip Code	<u>.ywoou</u>		10g. Citize	en of What Co	untry?		
	with s 23a ust b	Funeral	43803 Mustang Co	urt		206	36			USA			
	item:		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	I. Race - Amer Black, White	- American Indian,		
036	rs after or rall, or Examir	ed by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ★No If Yes, Give Year or Dates.		☐ Yes 2 🔀 No		Sp	pecify: Wh:				
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br	filed valued to the distribution of the vent, vent,		17. Father's Name (First, Middle, Last)				18. Mother's Nan	er's Name (First, Middle, Maid		den Surname)			
ylaı	ld be Menta arked atic e	욘	Robert McKinne	У			Franc		vey				
Maryland	shour and rism		19a. Informant's Name/Relationship (46.	ng Address (Street a							
e,	and 2 Health em 27 ther t		James R. Shook /	Husband	43803 b. Place of Dispo	Mustang	Court Ho	Date Date		y Land ation - City or	Z0636		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔀 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State		natory or other plac		2/2011_		-	Maryland		
Balt	permit. Depart Import any inj		21 Signature of Funeral Service Used	Lardines) 22	Matting P.O. Box	ss of Facility Ley-Gardi 270, Lec	ner Fun nardtow	eral n, Ma	Home, ryland	P·A0650		
П			23a. Part 1. Enter the disease, or con shock, or heart failure. List only		Approximate Interval Between								
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	End s	tage	Rena	1 dis	ease					
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90	cate be executed physician and the burial-transit	edical		d. <u>Diabet</u>	es n	nellitus							
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/Me									23d. Date of delivery Month Day Year		
Ö.	at the		Part II. Other significant conditions	contributing to death but not	resulting in the u	ınderlying cause giv	ven in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?		
S, F	ires the signer is signer if the period of the signer is signer in the signer in the signer is signer in the signer in the signer is signer in the	d by						1 🗆	Yes 2 □	lNo 3□P	Probably 4 Unknown		
Division of Vital Records, P.O.	w requ	Completed						24a. Was		24b. Were au	topsy findings available completion of cause of		
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<u>a</u>	iician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Newster			lace of Death (Che						
Š	Physic this or	은	1 Yes 2 No	Hospital: 1 Inpatient 2 28a. Date of injury	ER/Outpatie		4 ☐ Nursing F	lome 5 Res			cify)		
0 4	ding I h. After funer	ate	1 ☑ Natural 5 ☐ Pending	(Month, Day, Year)		work	yat ⟨? Yes 2 □ No	28d. Describe	now injury o	occurred			
Sio	Attendrated deat	Certificate:	2 Accident Investigation 3 Suicide 6 Could not 4 Homicide determined	be 28e. Place of Injury - At			163 2 110			Number or Ru	ural Route Number,		
<u> </u>	al or safte		determined	building, etc. (Spe	cify)			City or To	wn, State)				
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of my kn niner: On the basis of examina	owledge, death	occured at the time	e, date and place, a	and due to the c at the time, date	ause(s) and and place, a	manner as stand due to the	ated. cause(s) and manner stated.		
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	5 ¥ € 8		2-50. Signature and the procedurer	. 0					C Date	/19	1 11		
	•		30. Name and address of person who	ompleted cause of death (It	tem 23a) (Type		68923		7	1.11	(* '		
pu	0		Vijaya Lakshmi G	•		e Notch l	Road Holi	Lywood,	Mary1	Land 2	20636		
	Sta		31. Date filed (Month, Day, Year)	32. Pegistrar's Sig									
	Registr	ar	SEP 2 0 2011 Anna S. park										

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 15, 2011 10:40 ам William Lee Standish Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11740 Asbury Circle Calvert Solomons Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Hours 9/23/1920 Indiana 311-18-0344 Director 90 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Director 1 Yes 2 X No Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20688 U.S.A. 11740 Asbury Circle 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "mather any injury or other than "mather". 1 Never Married 2 Married Completed by 1 Yes 2 No Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clinton Standish Bertha Vellom 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23299 White Elm Court California MD 20619 Leslie Standish / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Kremation 3 Removal from State 4 Donation 5 Other (Specify) 9-20-2011 Brinsfield-Echols Charlotte Hall, MD Signature Femeral Service Iconsee

Edward N. Brinsfield Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final CHRONIC OBSTRUCTIVE PULLHONARY DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) 4 Pregnant : signed by the a d be detached for 9 ... Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown Division of Vital Records, 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform performed? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🔲 To the I within 2 To the I only one) 29b. Signature and title of certifie 40370

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State Registrar Peter

31. Date filed (Month, Day, Year)

110 Hospital Road, Prince Frederick, MD

20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Wisniewski,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day 11:12 AM Physician/ Darcetta Andres∈ Savoy 201 Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George Regional aurel Laurel If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔼 F Months Hours Min (Month 8 **,** Maryland 218-17-0334 July | Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10h County 10c. City, Town or Location Director be notified 1 X Yes 2 No Laure1 Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 0 10e. Street and Number 23a Funeral death with United States 20708 Examiner must 12803 Fernwood Turn 'natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc þ 1 Never Married 2 Married within 72 hours after Specify: Black Saltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) none Disabled Department of Health and Mental Hygier Important: If item 27 is marked otherway injury or other trans 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michelle L. Rountree မ Darcey Andrew Savoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20746 3416 Curtis Drive # 404 Suitland, Maryland Michelle L. Rountree - Mother 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of September cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Brentwood, Maryland 16, 2011 Ft. Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service License Stewar 20019 to her Washington, DC 4001 Benning Road NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Respiratory Distress Syndrome Physician/ disease or condition resulting in death) Medical Examiner piration rneumonid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin Erilepticus -transit Status or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month 4 ☐ Pregnant at time of death g ☐ Unknown ed by the a detached f 9 Unknown as been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by erebral 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N certificate has page 2 1 ☐ Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 X Inpatient 2 🗆 ER/Outpatient 3 DOA in 24 hours after death.

he Funeral Director: After this on pleted filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work?
1 Yes **Natural** 5 Pending 2 🗌 No 2 Accider
3 Suicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) S'eptember 8, 2011 7300 Van Dusen Road ress of pe son who combleted cause of death (Item 23a) (Type, Print)
II, MD Laurel Regional Hospital Nega Ali Goii, MD Laurel State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Physician/ 10:52 P.™ William M@Geary Spangler Sr. Sentember 18,2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15 Plantation Dr. <u>Haderstown</u> Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) e (State or Foreign Funeral 1 ★ M 2 □ F Days Hours Feb. 10, Months 1917 214-09-1656 94 Pennsylvania **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Washington 1 Yes 2 No Hagers town 10e. Street and Number 10g. Citizen of What Country? Funeral 15 Plantation Dr. 21740 U.S.A within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No 45
If Yes, Give Black, White, etc. 1 Never Married 2 Married <u>Ş</u> Maryland 21215-0036 1 Yes 2 No Specify White Specify: 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry should be filed within 72 In and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Farm Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna C. Smith George W. Spangler Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15 Plantation Dr. Hagerstown, Md. 21740 Elsie E. Spangler (Wife) Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Smithsburg Cemetery Sept. 22, 2011 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg, Md. Signature of Funeral Service Li 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 M01414 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death shock, or heart failure, List only one cause on each line Immediate Cause (Final Ph_{_}sician/ month disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, been sig should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director: After this certificate has b autopsy completed filled in by the funeral director, page 2 perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 ☐ Yes 2 ☑ No Hospital 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 2011 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Medical Campus Ros 21 Kugler MD 31. Date filed (Month, Day, Yeld) Begistrar's Signature State Registrar

DHMH 17 Rev 7/2009

ŧ	•			f Maryland / Depa	artment of Health and rtificate of Death	Mental Hygie	_	31184
П	Physicia Medic		1. Decedent's Name (First, Middle, Last)	Seha	M2 Jr.	2. Date of Death Month	Day Year	3. Time of Death
0	Examin		4a. Facility Name (if not institution, give street and num Citizens Care Rehabilitat	,	45. City, Town, or Location of Der Frederic		4c. County of Deat Frede	
	Funeral Director		545-26-4070 1 1 XM 2 □ F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi		9. Bird Co.	thplace (State or Foreign untry) 1 fornia
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State Md. Trederick	10c. City, Town or Lo Frede				10d. Inside City Limits
	th with the Maryland ms 23a or 28a-f show must be notified at	ral Dir	10e. Street and Number 1900 Rosemont Ave.		10f. Zip Code 21702	10	g. Citizen of What Co	ountry?
036	s after dea al", or ite Examiner	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Dece Armed For	ces? 2 \(\text{No} \)	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White	
Maryland 21215-0036	filed within 72 hours after dea tal Hygiene. Id other than "natural", or iter event, the Medical Examiner.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-2)	16a. Dece (Give	dent's Usual Occupation kind of work done during most of w O NOT use retired) ic Relation Pers	orking	6b. Kind of Business/	
/land 2	filed tal Hy od oth event	To Be	17. Father's Name (First, Middle, Last) Curt Max Schanz Sr.			ame (First, Middle, Ma a Bolander	iden Sumame)	
	1 and 2 should be f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Melanie Bryan (Guardiansh		ng Address (Street and Number or F Taney Ave. Fred			o Code)
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place) Sep	t. 21,	Oc. Location - City or Smi thsbur	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee		.L. Davis Funera	125	25 Bradbu	ry Ave.
Q	Physician Medical Examiner	r	23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition resulting in death) a. Due to (expectation of the condition of the conditi	aused the death. Do not entrolled ine.	er the mode of dying, such as cardi		,	Approximate Interval Between Onset and Death
30	e be executed ysician and ne burial-transit	dical Examiner	if any, leading to immediate Cause (Disease or injury that initiated events C.	or as a consequence of):				
), Box 6876	the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. Hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physimpletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	in the pact 12 months?	nant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	elivery Day Year
ls, P.O.	uires that the dea n signed by the at ald be detached f	ed by P	Part II. Other significant conditions contributing to de	eath but not resulting in the L	underlying cause given in Part I.	1	acco use contribute to	o the cause of death? Probably 4 Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should I	Complete				24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Vital	ysician: s certifica director,		25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outpatie	26. Place of Death (Cl			cify)
on of	ktending Ph death. ctor: After thi y the funeral	Certificate: 7	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation			28d. Describe how		
Divisi	tal or Atter rs after de al Directo	al Certii	3 Suicide 6 Could not be determined 28e. Place buildir	of Injury - At home, farm, str ig, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Atteno within 24 hours after deati To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check 2 Medical Examiner: On the base only one) 3 Contifying Nurse Practitioner:	s of examination and/or inves	tigation, in my opinion, death occurre	d at the time, date and I place, and due to the	place, and due to the cause(s) and manner a	cause(s) and manner stated. as stated.
	with con		29b. Signature are title of certifier	MD	DS839	29	d. Date signed (Monti	h, Day, Year)
61			SAJJAD A2121	e of death (Item 23a) (Type, F		e Ave,	Freder	iely, MD
1	Stat Registra		SEP 2 9 2011	egistrar's Signatu	ale			21701

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3 | 85
State of Maryland / Department of Health and Mental Hygiene

		•	State Registrar					Ce	rtificate of	Death			Reg. No.				
			1. Decedent's Name (First, Middle, Last)									2. Date of D		,	Year	3. Time of I	Death
	Physicia Medic		REGINA A					09/11,	/2011			1429	M				
	Examin		4a. Facility Name (in	f not institution	, give street and	d number)			4b. City, Town, o		n of Death		10.73	County o			
			Suburba		tal.				Bethesd					ontgo			
	Funeral		5. Social Security N		6. Sex	T F		st birthday)	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of B (Month, D 02/08)	irth <i>ay, Year)</i>		Coun	olace (State or ntry)	r Foreign
	Director		213-44-4				72	Yrs.				02/08	/1939		4D		
	or at	-	Usual Residence of 10a. State	10b. County		<u>.</u>	10c. City	, Town or Lo	cation						1	0d. Inside Cit	ty Limits
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	or 28	Director	10e. Street and Nu		<u> </u>		022		10f. Zip Code				10g. Cit	izen of Wi	nat Cour	ntry?	
	with th	la	8906 Pei		min Arro	niio			20910	1			USA				
	ath w	Funeral	11. Marital Status	шрутус	12. Was	Decedent	Ever in U.S	. 13.	Was Decedent of I	Hispanic C	Origin? (Spe	ecify Yes or No		14. Race		can Indian,	
(0	er de or it	by F	1 X Never Mar	ried 2 Mai	ried 1	ed Forces? Yes 2X	No		If Yes, specify Cub			Rican, etc.)			, White,	etc.	
03	saftı ral", Exal	pe k	3 🗌 Widowed	4 Divorced	If Ye	s, Give or Dates.			1 ☐ Yes 2 🛣N	o Speci	ty:			Specify:	Bla	.ck	
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7	with ygien her ther ther ther ther	Ö	12th						tologist					f-Em	отох	ea	
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χa	Ild be Men narke artic	-	Jake Tr	-								_					_
Maryland	shou and is n		19a. Informant's N						ing Address (Stree								101n
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		James T: 20a. Method of Dis		cotner		I non- D		Pennsyl	vanı		Date				own, State	1910
Baltimore,	ge 1 st of 1 s		1 🔀 Burial 2	☐ Cremation	3 🗌 Remova	I from State		emetery, cre	matory or other pla	ace)			1		-		
ţį	t. Page tment o rtant: If ijury or			5 Other (//	Gat		leaven Ce		09/1				777	na, MD)
Bal	permit. Page 1: Department of I Important: If it any injury or of		21. Signature of Fu	uneral Service	Lictrise	Lun	den		2. Name and Addr							0050	
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			shock, or hea	art failu/e. List	only one cause	on each lin	ne.		tor tria mode or ay			,			- 1	Interval Bet Onset and I MONT	ween
	Physician/ Medical		disease or conditi resulting in death)	iòn	a		cance								-	_/ mont	ns_
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		ē	Sequentially list c	onditions,	b. —	ue to (or as	a consequ	uence of):							_		
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2	and	Exa	that initiated even resulting in death)		c. D	ue to (or as	a consequ	uence of):									
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14J 8760	ficate g phy ss the	led				- J720							-				
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	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial bear and the should be detached for the same as the burial bear and the same as the su	Completed by Physician	in the past 12 1 Yes 2	X No	4 _	Pregnant Unknown	at time of	death 5	Other (specify)				-	Month Day Year			Year
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g E	sician: The law i certificate has birector, page 2 s	Be (25. Was case referexaminer?						I a		Death (Chec	ck only one)					
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io	ttend death tor; /	l≅	2 Accident 3 Suicide	6 Could	tigation and the transfer	Diago of Ir	sium: At h	ome form s	M 1		. LI NO	28f Location	(Street a	nd Numbe	r or Bur	al Route Numi	her.
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10	spital ours eral filled	g	29a. Certifier	1 X Certifyin	g Physician: To	the best of	of my know	ledge, deat	occured at the tir	ne, date a	nd place, a	nd due to the	cause(s) a	ind manne	er as sta	ted.	
9	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific geompleted filled in by the funeral director.	Medical Certificate:	(Chock	2 Madical	Evaminer: On t	he hasis of	examination	n and/or invi	estigation, in my opi	inion, deatl	h occurred :	at the time, dat	e and plac	e, and due	to the c	:ause(s) and ma	anner stated
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	•		30. Name and add	dress of persor	who complete	d cause of	death (Iter	n 23a) (Type	Print)								
			Nelson			54 Wi	scons	sin Av	enue, #1	300,	Chevy	7 Chase	, MD	208]	L5		
- 4	Sta		31. Date filed (Mor		014	2. Regis	trar's Signa	ture	es.								
	Registi	rar	SFF	152	UII /	and the	s B.	147 61									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month / W. George Taylor 1802 PM Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional medical Center Dalisburg Wicomico If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 214-28-2943 1 🗷 M 2 🗆 F Months Days Hours 02/22/1932 Maryland Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Wicomico 1 Yes 2 No Pittsville ö 10e. Street and Numbe 10f. Zip Code Examiner must be 10g. Citizen of What Country? Funeral 23a 8408 Whitesville Rd 21850 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 0. Black, White, etc. þ 1 Never Married 2 Married 1X Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", If Yes, Give Completed 3 X Widowed 4 Divorced ii Yes, Give Year or Dates, **Army** White Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry المالية. خوا Hygiene. مد than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the 2 should be filed with h and Mental Hygien 7 is marked other ti Owner/operator Antenna Service other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Neil Taylor Mary Hastings Department of Health and Important: If item 27 is n any injury or other traumone. 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town 32929 Melson Rd., Delmar, MD 21875 Charles Andrews/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 9/12/2011 Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 0 1 Dercapnels Medical o or as a consuluence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last physician Physician/Medical the attending IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown g Unknown is been signed by the should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 s autopsy performed? Yes 2 Avo death? After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 ၉ 1 Yes Other: 1 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1X Natural 5 Pending after death. Director: Aft 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined io the h⊾ within 24 hour⊾ To the Funeral Di \etated filler Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 only one) Signature ne and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Box 68760

Division of Vital

11-07105 Eulalia Galvan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ulalia Galvan	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No.	1101
Physician/ ledical Examiner	Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time Month Day Year 033	of Death 7 hrs
ledical Examiner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
Funeral Director	Johns Hopkins Bayview Medical Center 5. Social Security Number none 7. Age (In yrs. last birthday) yrs. Baltimore 6. Sex 7. Age (In yrs. last birthday) yrs. Nonths Days Hours Min. 6/09/1988 6/09/1988	State or
	Usual Residence of Decedent	side City Limits
D See any	MD Baltimore Dundalk	Yes 2 XNo
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1735 Burham Road 21222 Mexico	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fahe traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American India White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American India White, etc.	an, Black,
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lore, MD 21215-0036 uges 1 and 2 should be filed within 72 hours af it of Health and Mental Hygiene. it If item 27 is marked other than "natural other traumatic event, the Medical Examin To Be Completed by		
MD 212 d 2 should be lith and Ments n 27 is mark numatic even	19a. Informant's Name/Relationship (Type, Print) COMPario 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co Flisandro Diaz Lujan/ 1735 Burham Road Dundalk, Maryland	21222
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: Witern 27 is marked other ti injury or other traumatic event, the Med	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Panteon Municipal 9/30/201 Zacatecas, Mo	exico
Balti permit. Departu Import	21. Signety of Funeral'S rvis Licenses 22 Name and Folder Pass of The ALDI FUNERAL SERVICE, 9241 Columbia Blvd. Silver Spring,	
Physician /Medical		oximate Interval veen Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):	
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ansit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
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S, P.C. quires that an signed all be deta	1 Yes 2 No 3 Probably 4	ndings available
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for undrical Certification: To Be Completed by Physic	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 26 Place of Death (Check only one)	2 No
Vital hysician: this certif	25. Was case referred to medical examiner? 1 Ves 2 No 1 Ves 2 No 1 No	
ion of Vital I tending Physician: eath. oor: After this certifi the funeral director, ation: To Be C	27 Manager of Dogsth 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred	`
Division of spital or Attending I sours after death. neral Director: After filled in by the funer Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Homicide 1 Copecify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Rout or Town, State)	te Number, City
Di Within 24 hours a Within 24 hours a To the Funeral 1 Completely filled	29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause one)	e(s)
To the Hosp within 24 hosp within 24 hosp completely formatical Co	and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Date Signature 22) (Month, Date Signature 23) (Month, Date Signature	y, Year)
	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Stat	te 31. Date filed (Month, Day, Year) 1 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 3:15 A^M Yulan W11 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Collingswood Nursing Center Rockville 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday **Funeral** Hours Months (ear) 1929 China 214-11-0370 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 12020 Great Elm Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates er than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Elementary School Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Jie Qin Wang Xiao Zu Yu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12020 Great Elm Drive, Potomac, Maryland 20854 Jason C. Wu (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Method of Disposition September Metropolity ather place) 1 Burial 2 K Cremation 3 Removal from State 15, 2011 Alexandria, Virginia 4 Donation 5 Other (Specify) Crematory 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 M90689 Flant / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Accident Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician a Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 month
1 Yes 2 No Year Month Day Pregnant at time of death Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 💆 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28d Describe how injury occurred Certificate: injury 1 🗷 Natural 5 Pending 2 🗆 No Completed filled in by the f ☐ Accident ☐ Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and Mile ertifie 29c. License number 29d. Date signed (Month, Day, Year) September 13, 2011 D30132

Registrar
DHMH 17 Rev 7/2009

State

M. Rita Ghosh, 31. Date filed (Month, Day, Year)

15

Ghosh, M.D., 14812 Physicians Lane, #161, Rockville, Maryland 20850

me and address of person who completed cause of death (Item 23a) (Type, Print)

11-06956										
Virginia Wertz										

State of Maryland / Department of Health and Mental Hygiens Product Pro	1-06956		Please Typ	e or Print in B	A Donar	delible ir tment of	I K. Ensure Health and	Mental F	es Are Leg	201e.	1 31189
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29b. Signature and title of certifier O.C.M.E. September 15, 2011 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	Ospita hours uneral		4 Homicide	(0,000.7)	my knowledd	ne death occi	rred at the time da	ite and place a	and due to the caus	se(s) and manner as	stated.
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30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	To with Con	Mec			J		29c. Licens	e number		29d. Date signed	Month, Day, Year)
Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			Samuel Co Sounds	hoell wail			O.C.I	M.E.		September 15	, 2011
Pameia E. Southair, MD Assistant Medical Examiner 900 W. Baltimore Greek, Baltimore, MD 2.1220	(a										
State 31. Date filed (Month, Day, Year) SFP 16 2011 32. Registrar's Signature	Ψ							e Street, Ba	Itimore, MD 2	1223	
			nen 1 i		rar's Signatu	A. So	wed				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 19,2011 Sara E. Walker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth Birthplace (State or Foreign Funeral Months Days Hours Min. (Month, Day, 09/18/1930 Director Pennsulvania 222-18-4390 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location **Funeral Director** 28a-f 1 ☐ Yes 2 X No Aberdeen Harkord 10f Zip Code 10g. Citizen of What Country? 5 10e. Street and Number "natural", or items 23a U.S.A 21001 227 Woodland Green Way Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Yes, Give 3 ₩ Widowed 4 □ Divorced Year or Dates. White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Court Commissioner State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ada Neeper Herbert Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 230 Second Street West, Nokomis, Florida 34275 Cindy Mina (Daughter) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 g any injury or Tabernacle Cemetery 09/24/2011 Whiteford. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. gnatu of Funeral Service Licensee 123 S. Washington Street, Havre de Grace, MD that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, n each line. Approximate Interval Between Onset and Death Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events ig physician and as the burial-trai resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Shock 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed aortic aneurysm repair 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Investigation 6 Could not be 2 Accident 24 hours after deat Funeral Director; 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 ho

To the Fune (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D 63420 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

upper Unesapeake Dr - Bel Air , MD 21014

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend 20a-c 9/29/11 dk Golf Properties All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Day 17, Dorothy Louise Wiles 2011 8:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Frederick 4b. City, Town, or Location of Death **Examiner** Citizens Care & Rehabilitation Center Frederick Age (In yrs. last birthday) 90 Yrs Social Security Numbe If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-16-1304 1 □ M 2 💢 F Days Hours Oct 100 11 19 20 Mary Land Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland Frederick Frederick Y Yes 2 No 10g. Citizen of What Country? ems 23a or 7 r must be no Street and Number 1421 Taney Avenue, Apt. 130 10f. Zip Code 21702 Funeral permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2 any injury or other traumatic event; the Medical Examiner muss once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status þ 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) life. DO NOT use retireu) Seamstress Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ira Millard Wiles Elsie Regina Clingan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2129 Wainwright Ct., # 1A, Frederick, MD 21702 Mrs. Rosella Wiles, sister-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔼 Burial 2 🗌 Cremation 3 🗌 Removal from State Frederick MD 9/22/11 4 ☐ Donation 5 ☐ Other (Specify) Mt Olivet Cem . Signature of Kuneral Service Lic 22Keenevamd Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carding or respiratory arrest shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final disease or condition h sician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence or) Cause (Disease or linjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physician for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death on the runeral unrector. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I performe Yes 2 2 PNo 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural 5 Pendina iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registra 31. Date filed (Month, Day, Year) State Registrar

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ 10:30 A^M Sept. Florence Alexander Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Home Hyattsville Prince George's 8. Date of Birth 9. Birthplace (State or Foreign 5 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Days May 20 Massachusetts 1 □ M 2 🗓 F 98 Director 012-09-5507 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 💢 No Virginia Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral U.S.A. 22201 3625 North 10th Street 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Hospital 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ Mary T. Vaughn Laurence A. Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3625 N. 10th St. #402 Arlington, VA 22201 Carol Shottes (Niece 20c. Location - City or Town, State 20a. Method of Disposition 1 🖟 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 10-3-2011 Mt. Benedict Cemetery Donation 5 - Other (Specify) Boston, MA ²² Name and Address of Facility John H. Sawyer Funeral Home 329 Bunker Hill St., Charlestown, MA 02129 Si nature of Funeral Service Line 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia Sever disease or condition Medica! resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed by the attending physician and tached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 💹 No Month Year Day 1 Lites ∠ ⊊ 9 Lites ∠ ⊊ Unknown Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed be should be det Completed by ar dio vascular 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has ripheral 1 Yes 2 No this certificate 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \(\sum \) Yes 12 Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pendina work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier မ 0051122 1160 VAR NUM ST. NE #008 WOC, 20017 completed cause of death (Item 23a) (Type, Print) Juany smerando 32. Registraris Signature

Registrar

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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Physician/Medica	past 12 months?	E140 E	ant at time of dea	th " ==	tal death 3 ner (Specify)	lEctopic	pregnancy		Month	Da	y Year
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the bes miner:On the basis of and manner s	of examination and	e, death occur d/or investigat	red at the time, d	late and place n, death occ	ce, and due curred at the	to the cause time, date a	e(s) and manner and place, and du	as stated ue to the	cause(s)
F > F 8	Me	29b. Signature and title of certific			-	29c. Licens O.C.				29d. Date signe September	· ·	
2		30. Name and address of person Assistant Medical			,	altimore, MD	21223	<u></u>				
S	tate	31 Saterfiled Month, Pay, Year)	32. Re	gistrur's Signature	Ked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [- State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 26,2011 Lilvan M. Allen 7:09P Medical 4a. Facilify Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Balto. Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Days (Month, Day, Year) **Director** 213-30-7653 77 1 □ M 2 🛛 F Yrs 12-6-1933 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Md. Balto. Perry Hall 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 9509 Kingscroft Terrace Unit G 21128 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc þ 1 Never Married 2 XMarried 3altimore, Maryland 21215-0036 White 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12th Receptionist Insurance Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick Memmert Helen Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Milton F. Allen Spouse other Kingscroft terrace UnitG Perry Hall, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If is any injury or conce. 1 X Burial 2 Cremation 3 Removal from State Parkwood 10-1-2011 Parkville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Li 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph, sician/ disease or condition resulting in death) west Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin burial-transit requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year 9 Unknow Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law has autopsy performed? eral Director: After this certificate filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours a within 24 hours

To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my control at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. stemper 27 2011 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NA BonSecour Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 C 8. Date of Birth **Funeral** Months Days Hours 04-11-55 unk. Director 56 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director NA Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 21207 USA 3714 Gwynn Oak Avenue death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status
1 Never Married 2 Married 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. African Armed Forces?
1 ☐ Yes 2 🔀 No þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced Specify: American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th Grade 4 V r S • Masjid El Hagg Student Educator is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental ပ္ Zelda Jones Johnny Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21207 3714 Gwynn Oak Avenue Baltimore, of Health of Item 27 Gregory Carpenter-Friend other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot Date emetery, crematory or other place; 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King 09-28-11 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylle Funeral Home P.A. 21. Signature of Funeral Service Licensee, 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ANCROATIC Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last and-trar Physician/Medical death certificate be Records, P.O. Box 68760 nding physi use as the t use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Month Day the hed t 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 🗌 Yes Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to Be 26. Place of Death (Check only one) 1 Yes 2 X No မ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 o the F 29b. Signature and title 29d. Date signed (Month, Day, Year)

State

1940 W. BALTIMONE ST RALTU Med 2/223

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Sent. Physician/ 8:30A M Medical 4b. City, Town, of Louisian Commerce Baltimore

His Under 24 Hrs. or Location of Death 4c. County of Death Examiner 3020 Garrison 8. Date of Birth (Month, Day, 9-26-If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) **Funeral** Director 1 **M** M 2 □ F 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location **Funeral Director** CM timore 1 ¥Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 s 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industr (Give kind of work done during most of working fe. DO NOT use retired) College (1-4 or 5+) aintenance Be 18. Mother's Name (First, Middle, Maiden Surname) ည lora 19b. Mailing Address (Streetfand Number or Rural Route Number, City or Town, State, Zip Code) 14011 and 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cramatory or other) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funera Service Licensee D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart value. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESP disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Certificate: To Be Completed by Physician/Medical signed by the attending 23b. Was decedent pregnant 23d. Date of delivery ę in the past 12 months?

1 Yes 2 No Month Day Year within 24 hours after deatn.

To the Funeral Director: After this certificate has been signed by the encompletely filled in by the funeral director, page 2 should be detached formulately filled. 9 Unknown Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 N 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D00372 Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MP 301 MD Sinnature SEP 3 0 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gertrude F. Brewton Physician/ Sept. 1:00 A.M 28 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Harford County Hart Heritage Street Social Security Number (In yrs. last birthday) 93 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Months Hours Min. (Month, Day, Year) Oct. 28, 1917 Illinois 250-24-7077 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🄀 No Maryland Harford County Street 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 3708 Grier Nursery Road 21154 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes Give Completed 3 XWidowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home 12 t. Page 1 and 2 should be filed witt tment of Health and Mental Hygier trant: If item 27 is marked other 1 jury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Milda Ladwig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
255 River Road, Manchester, New Hampshire 03104 19a. Informant's Name/Relationship (Type, Print) Mr. Thomas Brewton (Son) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 Burial 2 X Cremation 3 Removal from State Evans Funeral Chapel 09/29/2011 Forest Hill, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services -Be
3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final Phy i i n disease or condition resulting in death) URINAMY Medical Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicia Funeral Director. De by the funeral director, page 2 should be detached for use as the bur. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Year Month Dav 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ြု 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29h. Signature and title Sept. 28, 2011 D39889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MM. Phail Belain, MD 21014

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 00 A. Physician/ 2DI/ Franklin Harold Behler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel Baltimore Washington Med. 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 🕅 M 2 □ F Days Hours Director 16,1917 186-01-4894 New York October Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Balto. Perry Hall 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3712 Perry Hall Road 21128 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black White etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 😾 Widowed 4 🗆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service Clerk 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mamie Baer Joseph S. Behler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. Desiree Melnychenko 303 Braeburn Glen Court Millersville, Md. 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Michael Luth. 10-1-2011 Balto.Md. 21. Signature of Funeral-Sep 22. Name and Address of Facility Schimunek Funeral Home Nottingham, Md. 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical n equence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or imjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown à signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at I Director: After the din by the funeral 28b. Time of 28d. Describe how injury occurred Natural Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contributing Nurse Pranticiper: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and the cause(s) and manner stated. (Check Certifying Nurse Prantioner: To the best of my knowledge, 29b. Signature and title of certifier 0 (Item 23a) (Type, Print) of person who completed cause of sital Dave, Wen Registrar

State of Maryland / Department of Health and Mental Hygien 20 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O Month 20^{Year} NANCY NIEDERBERGER BIK 1:19 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8557 Main Avenue Anne Arundel Pasadena Social Security Number If Under 1 Year | If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Min Hours 11 30 Day Country) 194 32 6399 71 **Director** PA Usual Residence of Decedent show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 8557 Main Avenue 21122 U.S.A. items filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Child Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marken any injury or **** Emmett Niederberger Nancy Margaret King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8557 Main Ave Eugene Bik - Husband Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 S Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/29/11 Loudon Park Cem Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, 169 Pasadena, <u>Riviera</u> Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ bou disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir -transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ò in the past 12 months? Dav Pregnant at time of death Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ardiomy obath 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autops performe 24 hours after death.

Funeral Director: After this certificate I leted filled in by the funeral director, pag. 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 ho

To the Fune

completed fi (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title icense number 29d. Date signed (Month, Day, Year) 34109 112611 30. Name and address of person who death m 23a) (Type, Print 31. Date filed (Mon State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physic Vedical Exam	ian/ iine	r Ann Mic	hele Ba	rker							Date of D Month Septem	eath			e of Death 25 hrs
j		4a. Facility Name (i 57 Salix Co		, give street and number	τ)			y, Town, o	or Location o	of Death			c. County of D Baltimore (
Funeral		5. Social Security N	lumber 6	5. Sex 7. A	ge (In yrs.	last birthday)		nder 1 Ye			8. Date of	Birth (MN	1/DD/YYYY) 9.		(State or
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiers the material", or items 23a or 23a-f she traumatic event, the Medical Examiner must be notified at once	Completed		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	,	P	rint	er				Fe	deral	Gover	nment
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y, MD 21215-00; and 2 should be filed with lealth and Mental Hygiene tem 27 is marked other th traumatic event, the Mes	o B	Joseph J. Robel Ann H. Rigby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or													
MD id 2 shoulth and in 27 is sumati	_	Ann H. De													A 17331
imore, MD Pages I and 2 sh nent of Health an aut: Witem 27 i		20a. Method of Disp		3 Removal from St	20b. F	Place of Dispo crematory or o	sition (N	ame of ce	metery,		ate		Location - City		
Baltimore, permit. Pages l ar Department of Hee Important: If ite		4 Donation 5	Other Spee		Mo-	tro Cro	emat	ory]	Inc.	09/2	8/11	В	altimo:	re, Ma	aryland
Balti permit. Departm Imports injury o		21. Signature of Fun	eral Service Lic	Thomas (Grego	r ²² C)	Name ar	d Addres	s of Facility SOCIE	ty .0.	f Mar		d, Inc		
Physician		23a. Part I. Enter the	disease of col	mplication, that caused	the death.	Do not enter	the mod	rede1	Such as car	diac or re	Balti spiratory a	MOre	, 'Mary.		21228 eximate Interval
/Medical Examiner		failure. List only Immediate Cause (F	inal disease	a.Atheroscle	eroti	c Card	iova	scu1a	ar Dis	ease					een Onset and Death
/		or condition resulting		Due to (or as a conse	equence of):									-
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6876 ertificat ling ph	an/M	IF FEMALE: 23b. Was decedent properties past 12 months?		23c. If yes, outcom	ne of pregn		etal deat	n 3[Ectopic p	regnancy			l. Date of deliv Month	ery Day	Year
Box 68760, e death certificate be the attending physic ed for use as the buri	Physician/Medi		9 🗸 Unknov	wn 9 Unknown	time of dea	ith 5 Ot	ther (Sp	ecify)						·	
		Part II. Other signific	cant conditions	s contributing to death	but not res	sulting in the ı	underlyin	ıg cause g	iven in Part	I.	23e. Did	tobacco u	use contribute	to the cause	of death?
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the started death. 3 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed by										1 Ye	es 2	No 3 P	obably 4	✓ Unknown
cord	Completed						_				24a, Was auto	psy	prior to	completion	dings available n of cause of
Vital Reco ysician: The law his certificate has director, page 2 sl		DE M									1 Yes	ormed?	death?		2 No
Vital hysician this cert	Be	25. Was case referred examiner?		Hospital: 1 Inpatier	nt 2 F	ER/Outpatient	2	26.Place	of Death (C			le			
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ivision of or Attending Phatter death. Director: After t	atio	1 Natural 2 Accident	5 Pending Investiga		rai)			1 Y	es 2 N	0					
Division Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certification:	- Guioldo	6 Could no	- 4	ury - At hon	ne, farm, stree	et, factor	y, office bu	uilding, etc.	28f.	Location (or Town,		d Number or F	Rural Route	Number, City
Hospit 24 hour Funers		4 Homicide 29a. Certifier (Check only 1 C		cian: To the best of my	knowledge	death occur	red at th	e timo do	to and place	and due					
Div To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	one) 2 M	edical Examine	er:On the basis of exam	ination and	d/or investigat	ion, in m	y opinion,	death occur	rred at the	time, date	se(s) and and plac	manner as stace, and due to	ated. the cause(s)
	Ž	29b. Signature and tit	le of certifier				29	c. License				29d. D	ate signed (M	onth, Day,	'ear)
2		Hamely	withell,	(, m)				O.C.N	1.E.			Sept	ember 25,	2011	
or been		30. Name and address Pamela E. So		completed cause of de Assistant Medic			W. B	altimore	Street, E	Baltimor	e MD 2	1223			
Sta		31. Date filed (Month,		32. P gistrar			10 1)			J, .VID Z				
Registr	'nг	SE	IP 3 U 2	UTT Brews		. DO CA	PC 30								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 | 2 0 | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M0751 2011 4:35 AΜ Betty Ann Bryant Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Berlin Worcester Carnegie Place 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 03-18-1929 Days Hours 216-48-1839 Maryland Director 82 Yrs. Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2 XNo Berlin Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral United States 7 Carnegie Place 21813 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify. WHITE Completed Specify: 3 ¥ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental I 27 is marked o traumatic eve Fred Browning Baldwin Hazel Belle Whiteford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a fitem 27 i Deborah Carven - DAUGHTER 12348 Vivian Street, BERLIN MARYLAND 21813 other Department of H Important: If ite any injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09-28-2011 Baltimore, Maryland Metro Crematory INC 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore Maryland 21228 wo art 1. Enter the disease, or commications that caused the disease or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition ISCHEMIC Medical resulting in death) Tue to (or as a consequence of) **Examiner** ersistant UnexP Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year signed by the a 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FRACTURE 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 🗆 No Yes 2 No 1 🗌 Yes the Funeral Director: After this certific npleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending 09-06-2011 8:00 PM 1 Tes 2 X No Fall Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined HOME 7 Canegie Place, Berlin MD Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records,

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Ry-Scheirer

29c. License number

40066462

10514 Racetrack Road, Unit C. Berlin Maryland 21811

9-28-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 31202 Robin Kelly Bisasky State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day Y September 25, 2011 BISASKY ROBIN KELLY **Medical Examiner** 1754 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6205 Scranton Road **Baltimore County** Rosedale 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Months Days Hours Director 47 219-80-2440 1 M 2 X F Country) 6-7-1964 Yrs MD Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. BALTIMORE ROSEDALE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6205 SCRANTON ROAD 盲 21237 U.S.A. Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes WHITE 3 Widowed 4 Divorced Yes, Give Year 1 Yes 2 X No specify: Specify: <u>چ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home WD 21215-0036 2 should be filed within 72 h and Mental Hygiene. 12 STEWARDESS **AIRLINES** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BISASKY WILLIAM AUGUST MARY MAGDALENE KRUEGER Be 19a. Informant's Name/Relationship (Type, Print) 1916 2011 gg Astrant Common Rhymber Brang House Dumper, 2 in yor Town, State, Zip Code) 3211 ဥ WILLIAM BISASKY/BROTHER 219 S. ATLANTIC AVE DAYTONA BEACH, FL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State timore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State SACRED HEART JESUS 9-30-2011 DUNDALK, MD Donation 5 Other Specify 21. Signature of Funeral Service License 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE. 21237 MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Metastatic Carcinoma Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical XX AMENDED#16a&b&19b PerINF G920 10/27/2011 JH the attending physician red for use as the burial -UNPENDED Box 68760, he death certificate be e IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month 2 Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. 支 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been s rector, page 2 should 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26 Place of Death (Check only one) or Attending Physician: Division of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene DOA After this 1 Yes ဥ 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 5 Pending 1 Yes 2 No Director: d in by the f death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) within 24 hours al determined the Hospital 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sa 2 Wadlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number September 26, 2011 O.C.M.E 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Russell Alexander MD. 31. Date filed (Month, Day Year) 32. Registrar's Signatur

DHMH 17 Rev 1/2001 OCMF 2006

State

Registrar

SEP 3 0 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener 31203 for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A hirthday If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 6398 1 M 2 □ F Months Hours 44 July 11, 1967 Mary land Yrs. **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 6702 Linden Avenue 21206 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married ģ 1 Yes 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use tritied) Painter 16b. Kind of Business Industry (Specify only highest grade completed) Self Employed Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Larry Zane Curry, Sr Linda L. Dix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Curry-mother 6702 Linden Avenue-Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Morelano Memoriai Park 1 Burial 2 Cremation 3 Removal from State Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 程 Van 8800 Vans Funeral 00 Harford and Cremation Services Parkville, Maryland 2123 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death the Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has perform 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes Other: 2 🗌 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation To the Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature title of certifier ne and add s of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar . Date filed (Month, May) Wear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 31204 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 24, 2011 Physician/ Diane Conley 2:30 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Forest Hill Health & Rehabilitation Harford Forest Hill Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 27, 1942 Massachusetts 1 M 25 X 69 Director 545-58-6391 Usual Residence of Decedent show 10a. State 10c. City, Town or Location must be notified at Director or 28a-f Harford Maryland Fallston 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 3201 Hunt Road 21047 ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 2 **X** No 1 ☐ Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Aberdeen Proving Gronds marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward E. Buchanan Dorothy E. Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to Faith Fuhrman / Niece 2261 Garrett Rd. Hanover, Pennsylvania 17331 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct.Da20. cemetery, crematory or other place) ¹XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. 2011 Arlington, Virginia 21. Signature of Funeral Service Licensee Evalus Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ante neug disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No signed by the atter Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown COPP 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate 1 🗌 Yes 2 🗌 No Yes completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Investigation 6 Could not be TAccident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination a new infragation, in my special part of the cause (s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D3225 September 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MacPhail Road Bel Air, Maryland Dr. David Dunn 31. Date filed (Month) Parryear) State Registrar

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🗸 U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Sept. 25, 12:25 PM Rose Coviello Mary Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery National Lutheran Home Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) NY Days Hours Jan. Day, Year 915 1 M 2 X F 049-05-9015 96 Yrs **Director** Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director 1 Yes 2X No Rockville MD Montgomery ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 20850 USA 9701 Veirs Drive Was Deceus.
Armed Forces?
Ves 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify "natural", 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Bookkeeper/Secretary Factory other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or ၉ Frances Silvestri Nicholas Panettierl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn L. Ward / Daughter 2813 Cameron Road, Falls Church, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 2 Cremation 3 Removal from State ò Department of Important: If any injury or once. Mountain Grove 10-11-2011 Donation Bridgeport, CT 5 Other (Specify) Signature of 22. Name and Address of Facility Parente-Lauro Funeral Home 559 Washington Ave., Bridgeport, CT 06604 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each licomplications that caused the deat. Do not enter to Immediate Cause (Final Onset and Death Phy i ian/ 1 1 disease or condition Medical resulting in death) Due to or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine e to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 month Day Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes 2 🗌 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other 1 🗌 Yes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA 4₺ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical

.7 Br

State Registrar 29a. Certifier (Check

Box 68760

P.O.

Division of Vital Records,

MD 26033 Ridge Road, Damascus, MD Charles Karesh, 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the call Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the call Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the call Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the call Certifying Nurse Practioner:

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

20872

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ELAINE CARPENTER Month - 17 - 2011 1925 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Casey House-Montgomery Hospice Rockville Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) DC **Funeral** 8. Date of Birth 1 M 2 X F Days Hours Min 06 1,8 4 19 40 216-64-3629 71 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MDMontgomery Silver Spring 1 XYes 2 ☐ No the 10e. Street and Number ò 10f. Zip Code ritems 23a or ner must be r 10g. Citizen of What Country? Funeral 20906 USA 4109 Collie Drive Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter edical Examiner 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. Completed 3 ☐ Widowed 4 K Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker of Health and Mental Hygitem 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Cora Ethel Myers ပ Bradford Woodrow Horton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13501 Spinning Wheel Dr., Germantown, MD 2087Department of Health ar Important: If item 27 is any injury or other trau David Carpenter/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cem. 20c. Location - City or Town, State Date 09-20-2011 Suitland, Maryland Donation 5 Other (Specify) Signature of Funeral Service Licensee 20746 22. Name and Address of Facility & Reil Cedar Hill FH,4111 PA Ave., Suitland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Rectovesicular Fistula use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical death certificate be Sacral Wound Infection Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Xunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law sate has page 2 s autopsy performed? this certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 🗀 No Other: ည ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

State Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

SEP 3 0 2011

Joseph, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0060634

6001 Muncaster Mill Rd., Rockville, MD 20855

29d. Date signed (Month, Day, Year) 09-18-2011

29c. License number

2 Medical Examiner: On the basis of examination array or investigation, in this opinion, seath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 31207 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician** JULIA H. CHAMPION 12:45 AM 09 18 2011 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 2696 Walston Rd Mount Airy If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04 23 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 1 F 22 0765 83 Vre 1928 Director MD Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2696 Walston Rd 21771 U.S.A. "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iter any Injury or other traumatic event, Item Medical Exemination 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: ò Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Michalski Helena Raesler 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7580 Beach Dr Sharon Champion - daughter Pasadena, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 9/23/11 Meadowridge Mem Pk Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home, 21. Signature of Functal Sovice Licensee 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conse nce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform of Vital 1 □ Yes 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier time certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person

Year)

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O | AMEND ITEM#10f, 19b, perff, 6920, 10/19/2011, WS Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CoKen Physician/ Sepetomber Day ond Agno 4.40A M Medical 4a. Facility Name (if not distipation, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nsg Ctr. Balt: Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs, last birthday) If Under 24 Hrs. 8. Date of Birth 2804 1 □ M 2 🕽 F Days Hours TRS Director Yrs 98 SC Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location Baltimore Examiner must be notified at 10d. Inside City Limits Director N/A MD 1 X Yes 2 No 10e Street and Number 9 Zip Cod 10g, Citizen of What Country? Funeral 1017 Darthmouth Glen Way items 23a USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【X No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🗓 No Specify: Black "natural", Specify: Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Balto. City School Food Service 2vrs Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hv. Important: If item 27 is markany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown 2 Susan Woodruff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Adgate Street and Mymboy or Rural Route Number, City or Town, State, Zip Code) 6829 Queensbury Rd. Balto., MD 21239 Angela Martin-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/30/2011 Randallstown, Memorial Pk. 22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202 Signature of Peneral Service Licenses 1/ Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons a uence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Duerto (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 ≝ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed? Yes 2 X/No 2 **Zi**No 1 🗌 Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Mursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral of 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ertifier 29c. License number 29d. Data signed (Month, Day, Year) Beflewber 22 2011 3060 30. Name and address of person who completed cause of death (Item 2Ba) (Type, Print) Laven Blvd 32. Registra 's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 31209 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 15:19 PM **Physician** В September lames 2011 can /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year) Sep 05, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 2 M 2 □ F 68 Maryland 212-42-1611 1943 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show 1 ☐ Yes 2 No notified Director Baltimore Dundalk 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 5 must be 23a 7432 Old Battle Grove Road 21222 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ral", or Iten Examiner Black, White, etc. 1 XYes 2 □ N If Yes, Give Year or Dates: √ 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 Divorced "natural" main Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4 or 5+) id Mental Hygiene. marked other than Automotive Master Instructor traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry August Dean Ellen Jane Marsh ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and is mi 19a. Informant's Name/Relationship (Type, Print) Mary Dean /Wife Health tem 27 I 7432 Old Battle Grove Road Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. Sep 28 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Beltsville, Maryland 2011 4 Donation 5 Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licensee . 22. Nersendadden of and Funeral Alternatives M01443 Ritte 8717 Green Pastures Drive Towson Maryland 21286 NU 23a. Part 1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final y barachroid **Physician** ntractivosa disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner (ommunicat Anterior Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine nding physician and use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Director: After this certificate has 2 🗌 No 1 Yes 1 Tes director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 1 X Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA မှ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I or Attending F after death. 1 X Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the f 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) R95-000 torton September 22 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001 11595

State

Registrar

31. Date filed (Month, Day, Year)

3 0 2011

Page Not Found

State Registrar 30. Name and

JACKIE

31. Date filed (Month, Day,

JONES,

8:45

2011

SEPTEMBER 27,

MARY DULANEY

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

ddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3 | 2 | 2 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Jennie Sept. Mildred 26, Medical 2:30 Ам 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Wheaton Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Nov. 28 Min. Year 1910 **Director** 004-38-4079 100 Yrs Canada Usual Residence of Decedent 28a-f show 10a, State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Montgomery 1 X Yes 2 ☐ No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13211 Ewood Lane 20906 U.S.A. death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 within 72 hours after 3 ☒ Widowed 4 ☐ Divorced If Yes, Give 1 Yes 2 No Specify: Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Nursing/Medical 17. Father's Name (First, Middle, Last) and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Clarence Kinney permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Amy Kilpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garland Day (Son) 124 West Washington St., Orange, VA 22960 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial Argremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 9 - 27 - 11Alexandria, VA 21. Signature of Funeral Service Licen 22. Name and Address of Facility Preddy Funeral Home 250 W. Main St., Or Minne Orange 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Physician/ Onset and Death Urosepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the bunal-tranresulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery Month 1 ☐ Yes ∠ 4 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖰 Unknown Alzheimer's Disease 24b. Were autopsy findings available r this certificate has ral director, page 2: autopsy prior to completion of cause of performed? Yes 2 X No death? 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) ၉ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of After 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident after death Investigation 1 Yes 2 No filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune

completed fi 29a. Certifier 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52261 9-26-11

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of dea

Alan Segal, MD

31. Date filed (Month, Day, Year SEP 3 0 2011 Wheaton, MD

th (Item 23a) (Type, Py

110901 Georgia Avenue

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DAVIS SEPTEMBER 28 2011 GLADYS 2:40 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12916 FOX BOW DRIVE #203 UPPER MARLBORO PRINCE GEORGE'S 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Months OCT . I7 1 M 2 X F Hours ^{rear)}916_ NORTH CAROLINA **Director** 245-07-2191 Usual Residence of Decedent 28a-f shov death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified MD1 Tyres 2 No PRINCE GEORGE'S UPPER MARLBORO ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12916 FOX BOW DRIVE #203 20774 USA ral", or items ? I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK "natural" 3 X Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12TH SILK FINISHER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file n and Mental I is marked o ပ္ ED MILES BEATRICE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. NANCY MOONEY/DGT. 807 PENGROVE COURT BOWIE, MARYLAND 20716 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) MD NATIONAL CEMETERY: 10-4-2011 LLAUREL MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1 / Enter the shock or heart f disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph_sician/ disease or condition ADVANCED DEMENTIA Medical resulting in death) Due to (or as a consequence of) **Examiner** HYPERTENSION Sequentially list conditions, if any leading land cause. Enter Underlying Examiner Directo for as a consequence of sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the buria Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Month 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, HISTORY OF STROKE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No DEPRESSION 24a. Was an page 2 s autopsy performed? Yes 2X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 K Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours

To the Funeral Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MB D51437 SEPTEMBER 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IBITOYE M.D. 12200 ANNAPOLIS ROAD # 232 GLENN DALE, MARYLAND 20769 **OKEOWO**

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are L State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	tate of marylan		ate of Dea				g. No.		V 1 L 1
Physici		Decedent's Name (First, Mide				-		Date of Death			3. Time of Death
Medical Exami	ner	Scott Jason						Month September			0010 hrs
		4a. Facility Name (if not instituti W/B Route 70, mile r		er)		, Town, or Location o	of Death		4c. County Howard		
Funera!		5. Social Security Number		Age (In yrs. last bi			er 24Hrs. 8	B. Date of Birth			nplace (State or
Director		217-23-5816	1X M 2 F	22	Yrs. Mor			02-11-		Foreign	
		Usual Residence of Decedent	121 W 2 1		115.				1,0,		
any		10a. State 10b. County		10c. City, Towr	or Location						10d. Inside City Limits
Aaryland 28a-f show Latonce	ō	MD Ho	ward		Columbia						1 Yes 2 X No
Maryl. 28a-f	Director	10e. Street and Number	-	•	10f. Z	ip Code		109	g. Citizen of W		try?
death with the Maryland or items 23a or 28a-f sho must be notified at once.		5476 Endicot	t Lane			21044			U.S.	Α.	
th wit	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was Decede		13. Was Dece If Yes, spe	dent of Hispanic Orig cify Cuban, Mexican	gin? (Speci . Puerto Ric	fy Yes or No- an, etc.)		e, etc.	an Indian, Black,
er dea	Ē		1XX Yes	2 No		2XX No specify:			Canaitu	7.71	nite
ırs aft tural"	ξ	15. Decedent's Education (Spe	or Dates:	completed) 16a.		al Occupation (Give		done	Specify: 16b. Kind of Bu		
5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)		during most of working life. DO NOT							,
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15-00. Iled withi Hygiene. I other ti	ပိ	17. Father's Name (First, Middle							aiden Surname))	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-7 she natic event, the Medical Examiner must be notified at once	Be	Walter Albert 19a. Informant's Name/Relations	and the same of th	Sue Fis							
MD 2 d 2 shoul th and N n 27 is m	၉		(Mother)			ss (Street and Num isman Lan					Zip Code)
		Lisa Heflin 20a. Method of Disposition	(Hother)	20b. Place	of Disposition (N	ame of cemetery,			20c. Location		fown, State
MOFE Pages 1 net of H nt: Lf if		1 X Burial 2 Cremation	_	Otate	tory or other plac t Lawn C		0-30	_2011	Morrio	\++ 011	ille, MD
Baltimore, permit. Pages I ar Department of Hes Important: If its injury or other tr		4 Donation 5 Other S 21. Signature of Funeral Service		0168		nd Address of Facility					<u> </u>
	. 6	Malula 70	1	4		Twin Knol	WILZ.	ke rune ad Co	eral Ho olumbia	mes, , MD	21045
Physician		23a. Part I. Enter the disease, or failure. List only one cause		ed the death. Do n	ot enter the mode	e of dying, such as c	ardiac or re	spiratory arres	t, shock, or he	art	Approximate Interval Between Onset and
/Medical	Immediate Cause (Final disease a. Multiple Blunt Force Injuries										Death
		or condition resulting in death)	Due to (or as a cor	nsequence of):					_		
	9	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cor	nsequence of):			-		 -	\dashv	
	Examiner	cause. Enter Underlying Cause (Disease of injury that initiated	C								
ited i ansit	E S	events resulting in death) Last	Due to (or as a cord.	nsequence or):						1	
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED								
60, ate be shysici	S S	IF FEMALE:	23c. If yes, outo	ome of pregnancy					23d. Date of	delivery	
687 ertific ding p		23b. Was decedent pregnant in the past 12 months?	LIVE DITTI		2 Fetal deat	h 3 Ectopio	3 Ectopic pregnancy Mo				ay Year
Box 687 be death certific the attending pred for use as the	Physician/	1 Yes 2 No 9 Un	4 Pregnant	at time of death	5 Other (Sp	ecify)			1		
that the d		Part ii. Other significant condit		ath but not resultin	g in the underlying	ng cause given in Pa	rt I.	23e. Did toba	acco use contr	ibute to th	ne cause of death?
i, P.O.	d b							1 Yes	2 🗸 No 3	Probe	ibly 4 Unknown
ords, w requires been should	Completed							24a. Was an			opsy findings available
Recol The law	티							autopsy perform 1 ✓ Yes 2	<u>ed</u> ? (death?	mpletion of cause of
tal Recian: The certificate ector, page		25. Was case referred to medica				26.Place of Death	Check only	(163	2 110
Vital I nysician: this certifi director,	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	tient 2 ER/O	utpatient 3	DOA Other	Nursing H	ome 5 R	esidence 6	Other:	Scene
n of Vi ding Physi After this funeral dir	اچا	27. Manner of Death	28a. Date of Ir (Month, Day Sep 26, 20	njury 28b.	Time of Injury	28c. Injury at Work	ID ri	d. Describe ho	w injury occurr ycle truck (ed	who was
sion trend death.	igi gi	1 Natural 5 Pend 2 ✓ Accident Inve	stigation		0 hrs	1 Yes 2 🗸	sub	sequently		,01113101	WIIO Was
Division of Vital Records, tal or Attending Physician: The law require rs after death. **I Director: After this certificate has been siled in by the finneral director, page 2 should be	Certification:		d not be			ry, office building, etc		or Town, Sta	te)		al Route Number, City
ospita hours hours		4 Homicide	(0,000))	terstate/Expre					mile marker		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only	hysician: To the best of miner:On the basis of ex	amination and/or							
S with	Mec	29b. Signature and title of certifie	and manner state	d,	25	9c, License number		1:	29d. Date sign	ed (Mont	h, Day, Year)
		1.1-	-/ M	r		O.C.M.E.			September	26, 20	11
10	-	30. Name and address of person	who completed cause of	death (Item 23a)							
ι		Russell Alexander MD				Itimore Street,	Baltimore	e, MD 2122	23		
	ate	31. Date filed (Month, Day Year)	2011 Registr	rar's Signature	backer						
Regist	nen	JLF 0 0	Auto						OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Frank P. Doetzer, Jr. 8:30 September ⁹19 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Elizabeth Nursing Center **Baltimore** N/A Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Jan 28 Hours Marvland **Director** T922 89 215-16-1544 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Md. 1 Yes 2 No Anne Arundel Co. N. Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 307 Charles Rd. 21090 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 V Yes 2 If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 ☐ Divorced Year or Dates. WW II White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tool & Die Maker Revere Copper & Brass Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Doetzer Amelia Keis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 Sunnyfield Lane Balto. Md. 21225 Carolyn Doetzer, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 9/23/2011 Baltimore, Md. 22. Name and Address of Facility Gonce_Funeral_Service P.A. 21. Signature of Funeral Service Licensee mommowsky 4001 Ritchie Hgwy. Balto. Md. 21225 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ monary disease or condition Medical Examiner resulting in death) Metabo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by extindencia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy perform 1 Yes 2 X No 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death.
I Director: Aff work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. Jackie Leroy Der 26, 20T1 2:30p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 20 Winona Avenue Baltimore Co. Dundalk Social Security Number 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 2-18-1937 Months Min Hours 212-32-8854 Maryland **Director** Yrs Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Co. Dundalk 1 Yes 2 X No 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 20 Winona Avenue 21222 USA 12. Was Decedent Ever in U.S. Armed Forces?

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1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Year Day Pregnant at time of death should be detached the Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has bade 2 autopsy performe this certificate 1 Yes 2 No 1 Yes 2 X No director, 25. Was case referred to medica B B 26. Place of Death (Check only one) Hospital 2 🔀 No 1 Tyes Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1 🕅 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 🗆 Homicide Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 27, 10X completed cause of death (Item 23a) (Type, Prin

State Registrar

DHMH 17 Rev 1/2001

Box 68760,

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JEOR9E DRSE Physician/ Month 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Halthorpe 934 Palladi Drive Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 220-38-5953 1**XX**M 2 □ F Director 10-28-1942 Maryland 68 Usual Residence of Deceden 28a-f shov 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits be notified at Director Halthorpe 1 Yes 2 No MD Baltimore 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a United States 21227 934 Palladi Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ŗ, by 1 Never Married 2 Married Yes 2x XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: "natural" Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working er than the Me life. DO NOT use retired) ntal Hygiene. ed other than event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Union Sprinkler Fitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever မ Grace Matilda Tharle George Alfred Dorsey, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 934 Palladi Drive, Halthorpe, Maryland 21227 Anna F. Dorsey - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10-03-2011 Elkridge, Maryland Meadowridge Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus _____each line. Approximate Interval Between Deset and Death Immediate Cause (Final Physician. DANGRENE MO.UTHI disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at Id be detached for Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has ; page 2 s autopsy certificate 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 2 . No ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 5 Pending injury Accident Investigation 24 hours after deat Funeral Director; 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hou

To the Funer

completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Mirse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day

State Registrar

DHMH 17 Rev 06-2011

of person who completed cause of death (Item

3 0 2011

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 27, Nancy Ann Edrington 2011 2:35 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore . Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York **Funeral** 8. Date of Birth 1 □ M 2 🔀 F Days Hours 8/20/1929 058-26-9405 **Director** 82 Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore 1 Tes 2 X No 10e. Street and Number ō 10f. Zip Code must be r 10g, Citizen of What Country? within 72 hours after death with Funeral Camber ley Circle 21204 U.S.A. "natural", or iterr ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ð 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates White the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ge 1 and 2 should be filed within 73 nt of Health and Mental Hygiene. It if item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Medical Occupational Therapist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Heilman Iva Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon A. Brookhart/ Daughter 1512 Green Mill Road Finksburg, Maryland 21048 Baltimore, Department of He Important; If items any injure 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Lorraine Park Cem. 10/3/2011 | Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. ice Lice 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ S disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any hadding to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Baquerice of): burial-transit Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical that the death certificate be P.O. Box 68760 SEPTEMBER IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Month Day sate has been signed by the s page 2 should be detached t Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ the Hospital or Attending Physician; The law requires Division of Vital Records. Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed certificate 21 1 Yes B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director; After thi 27. Manny of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 V Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ella 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNECIA WHITE, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 32. Registrar's Signature Registrar

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) 31220 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John G. Evans, Jr. September 2011 6:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Social Security Numbe If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 213-54-3015 Director 1 🕱 M 2 🗆 F 46 Feb 17, 1965 Maryland Usual Residence of Decede 28a-f show 10a. State with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. Baltimore Parkville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7830 Ridgely Oak Rd. 21234 USA permit. Page 1 and 2 should be filed within 72 hours after death a popartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Completed 3 XWidowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) +2 Elementary/Secondary (0-12) Self Employed Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John G. Evans, Sr. Rosalyn Schilpp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD. 21204 321 Southwind Rd. John G. Evans, Sr./ Father 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5/ ☐ Other (Specify) 9-30-11 Hilltop Service Co. Towson, MD. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Funeral Home, Rd. Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury / the attending physician and ched for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day 1 Yes 2 L 9 Unknown detached signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes completely filled in by the funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No 1 🗌 Yes 2 🖸 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Beath 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural death. 2 Accident
3 Suicide
4 Homicide Accident Investigation 1 Tyes 2 🗆 No within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

30

2011

Registrar's Signature

11-07091 Gregory Flowers Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | | State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Certific	cate of	Death			R	eg. No.		
Physici "cal Exam		Decedent's Name (First, Middl Gregory	le,Last) Flowers		-				2	2. Date of Dea Month Septembe	th Day Yea er 20, 2011	r	3. Time of Death 1509 hrs
		4a. Facility Name (if not institution 911 Leadenhall Street		umber)		46	. City, Town, Baltimore	or Location	of Death	000000000000000000000000000000000000000	4c. County o		
Funeral		Social Security Number	6. Sex	7. Age (I	n yrs. last bi	irthday)	If Under 1 Y	ear If Und	der 24Hrs.	8. Date of Bir	th (MM/DD/YYYY)	9. Birt	hplace (State or
Director		025-46-7039	1XM 2 F		55	Yrs.	Months D	ays Hou	rs Min.	12/06	/1955	Foreig Cou	Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10	c. City, Tow	n or Locatio	n						10d. Inside City Limits
M 0	or	MD					Ba1	timor	e				1 Yes 2 X No
15-0036 filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once.	Director	10e. Street and Number					10f. Zip Code			1	0g. Citizen of Wh		try?
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212 ould be d Ment s mark		19a. Informant's Name/Relations		СЦ	19	9b. Mailing A	Address (Str				nber, City or Town	, State,	Zip Code)
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Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		1 Burial 2 Cremation		rom State	crema	atory or othe	r place)	•					
Baltimo permit. Page Department of Important: injury or ott		4 Donation 5 Other Sp 21. Signature of Funeral Service		Λ.	FOIL		In Cemo				ins Funer		Maryland Home
		Washney N	. Corr	relu	W	74	74 Land	lover	Road	, Lando	over, Ma	ry1a	nd 20785
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Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensi Due to (or as			ic Cardio	vascular D	isease			· · · · · · · ·		Death
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Box 687 be death certifi. the attending hed for use as t	Physiciar	past 12 months? 1 Yes 2 No 9 Unk		nant at time			r (Specify)				110		
O. B at the de 1 by the		Part il. Other significant conditi			t not resultir	ng in the und	derlying cause	given in P	art I.	23e. Did to	bacco use contrib	oute to t	ne cause of death?
ires that the signed by	g b	Diabetes Mellitus								1 Yes	2 No 3	Proba	ably 4 🗹 Unknown
Qivision of Vital Records, all or Attending Physician: The law require s after death. In Director: After this certificate has been side of in by the funeral director, page 2 should be	Completed									24a. Was autop	sy pr	ior to co	opsy findings available ompletion of cause of
tal Rec cian: The l certificate b ector, page	S									1 Yes		eath? ✔ Yes	2 No
Vital ysician his cert directo	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Magnital: -	Inpatient	2 ER/C	Outpatient :			(Check on Nursing	-	Residence 6	Other:	Scene
1 Of ling Ph After t funeral	اڃ	27. Manner of Death		of Injury , Day,Year)	28b.	Time of Inju	´ l	jury at Wor	k? 2		now injury occurre		
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PIVISION of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	edical C		nysician: To the bes										
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St	ate	Ana Rubio MD. Ass 31. Date filed (Manth, Day, Year)	istant Medical	=xamıne				, Baitime	ore, MD	21223			
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4	For State Of IVI		artment of Health an	id Mental Hyg	ien 20	3 2 2 2
	Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Death	2. Date of Death	eg. No.	O Time of Death
Physician/ Medical	Patricia Lynn Fran	cis		Septemb		3. Time of Death 8:10AM
Examiner 4	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of D		4c. County of Deat	
Funeral	5138 Beaverbrook Road 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	Columbia If Under 1 Year If Under 24	Hrs. 8. Date of Birth	Howa 9. Birt	hplace (State or Foreign
Director	215-56-7928 1 □ M 2 🕮 F	58 Yrs.	Months Days Hours N	Min. (Month, Day, 11-19-1		untry)
nd how at	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation	11-19-1	932 Mai	yland 10d. Inside City Limits
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Urs aft ural", al Exa	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2 X No Specify:		Specify: W	nite
21215-003 idthin 72 hours a liene. r than "natural" the Medical Ex.	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give k	ent's Usual Occupation kind of work done during most of O NOT use retired) V.P. O	working	16b. Kind of Business/	Industry
21215-0036 within 72 hours after giene. er than "natural", o , the Medical Exam Completed by	Elementary/Secondary (0-12) College (1-4 or 5	Resou	rces and Financ	e Human	Biotechnol	ogy
and 2	17. Father's Name (First, Middle, Last)	<u> </u>	18. Mother's	Name (First, Middle, M	laiden Surname)	
Maryland 2 should be filed thth and Mental Hy 27 is marked oth traumatic event To Be	Earl Lowe			nna Hancoc		
Ma 12 sho 14 shoulth and 27 is 1	19a. Informant's Name/Relationship (Type, Print) Raymond Francis (Husband)	1.0	g Address (Street and Number of Beaverbrook Ro		City or Town, State, Zip Bia, MD 21	
of Hear fittem	20a. Method of Disposition	20b. Place of Dispos			20c. Location - City or	
Baltimore, oermit. Page 1 and Department of Her Important: If item any injury or othe page.	1 ☐ Burial 2 XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			29-2011	Glen Burn	ie, MD
Baltimore, Mispermit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra once.	21. Signature of Funeral Service Ligensee		Name and Address of Facility. 555 Twin Knolls		neral Home lumbia, MD	
	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	I the death. Do not ente	r the mode of dying, such as care	diac or respiratory arres	st,	Approximate Interval Between
Physician	Immediate Cause (Final disease or condition resulting in death)	Arrhyth,	nia			Onset and Death
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De de la la la la la la la la la la la la la	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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he Hospita in 24 hours he Funeral plettely fille	29a. Certifier (Check (Check only one) (Check only one) (Certifying Physician; To the best of a Medical Examiner; On the basis of examiner; To the	kamination and/or investi	gation, in my opinion, death occur	red at the time, date and	place, and due to the o	ause(s) and manner stated.
To the thick the	29b. Signature and title of cortifier	Q.	29c. License number	29	d. Date signed (Month	, Day, Year)
	- Than Maharl	MI	D0055810)	9,28	, 2011
(O)	30. Name and address of person who completed cause of de Jyothi Rao-Mahadevia, M.D.	eatn (item 23a) (Type, Pi 4801 Dor	sey Hall Drive	#201 Elli	cott City,	MD 21042
State ⁸ Registrar	SEP 3 0 2011 32. Registra	r's Signature	rint) sey Hall Drive			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23b per doc g919 9-30-11 vt 30 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ferguson Year Emma Lee 05M Medical 0 01 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore AG nes Hosbita If Under 1 Year If Under 24 Hrs. Funeral 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 ☐ M 2**X**☐ F Hours Min. (Month, Day, Year, Director 80 251-56-5406 08 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore MD NA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21223 2614 Lauretta Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Black 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Worker 2th grade Domestic na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hessie Young Do Johnson 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21229 Baltimore, Ernestine Davenport 407 Rosecroft Terrace, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 9/17/2011 Baltimore, Zion native of Funeral Service Licens 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death nmediate Cause (Final Physician/ espirators disease or condition Medical resulting in death) Ü Examiner Pneumonia Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner sequence of Cause (Disease or linjury ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy this certificate 1 Yes 2 No 2 N Hospital or Attending Physician; **Division of Vital** completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge namer as étal. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Sept 10 2011 60716 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1362 66L 7.0 JOHA St. Agnes Hospital 31. Date filed (Morith, Day, State 30 SFP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:35 AM Silvana Maria Ferres Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie <u>Anne</u> Arunde1 5. Social Security Number Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 1 □ M XX F Days Month, Day, Year / 15 / 1929 Months Hours Min. (Month, Director 214-46-1269 Trieste Usual Residence of Decedent hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Tes 2XXNo Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 607 Deering Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2XXNo If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Baltimore, Maryland 21215-003 3 Widowed 4XXDivorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the once. Factory Worker other Maryland Paper Box Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Giovanni 01ia Erminia Fercovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Donna Ferres / Daughter 12328 Honeysuckle Road Fort Myers, FL 33966 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2XXCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 9/30/2011 Glen Burnie, MD of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the dise Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of leach line. Interval Between Onset and Death Immediate Cause (Final Physician comier disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 5 Other (specify) Day Pregnant at time of death Month Year 1 Yes 2 Unknown the 9 Unknown signed by t. d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown Completed 1 Yes 2 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy performed certificate 2 🗌 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: Certificate: To No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this d in by the funeral di 27. Manner of Dea 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural Accider 5 Pending iniury Accident Suicide Investigation 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 2011 30. Name and address on who completed cause of death (Item 23a) (Type, Print State Registrar

DHMH 17 Rev 7/2009

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 31226 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ Medical Examiner 4c. County of Death more 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 10-2761 **Director** 1 **X**M 2 □ F Usual Residence of Decedent 28a-f show 10b. County ms 23a or 28a-f shor 10a. State 10c. City, Town or Location Director Himore 1 Cres 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral mous items 12. Was Decedent Ever in U.S. Armed Forces?

Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, is marked other than "natural", or itel aumatic event, the Medical Examiner þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working DO NOT use retired) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ဂ 27 is marker r traumatic e 19a. Informant's Name/Relationship (Type, Print) cus q Laco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Method of Disposition 20b. Place of Disposition (Name 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Euneral Servic Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of thing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ alcoholic disease or condition MO Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last CAD use as the burial-tran Due to (or as a consequence of): is certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? hin 24 hours after death.

the Funeral Director: After this certificate Yes 1 Tes 2 / No 25. Was case referred to medical Division of Vital Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ည 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 - Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 1 \square Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within To the 29b. Signature and title of certifier 43172 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 515 owson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 31227 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 27, 2011 7:15 P. M Medical Janice Pierce Green 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Days July 28, 1937 Hours North Carolina **Director** 74 243-50-6674 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2xXNo Maryland Harford Bel Air ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 819 Rock Spring Road United States 21014 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc 1 Never Married 2 Married 'natural", or þ White 1 Yes 2XXNo Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Education Teacher and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joshua Pierce Katherine Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 819 Rock Spring Road Bel Air, Maryland 21014 Department of Health a Important: If item 27 is any injury or other traionce. Charles E. Green / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Sept. 29, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Air 21. Signatur / Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service—BelAir boud 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ CONGESTIVE HEART PAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ISCHEMIC CARDIOMY OPATHY Sequentially list conditions. Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ARTERY BISEASE CORONARY that initiated events resulting in death) Last Completed by Physician/Medical IF FEMALE 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 **P**No 1 Yes 2 9 Unknown Month Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES TYPE 1 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown HYPOTHYROIDISM. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy HYPERTENSION performed? Yes 2 Van Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ✔No Hospital: Other: 4 \(\text{\text{Nursing Home}} \) 1 \(\text{\text{Residence}} \) 1 \(\text{\text{Other}} \) 2 \(\text{\text{Other}} \) 2 \(\text{\text{Other}} \) 1 \(\text{\text{Constant}} ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town. State 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Andrew Nowshows up 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 35 FULFORD AVE BELATR, MD 2014 STUDREN NOWAKOWSKI MD Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Grogan September 25 2158 PM 2011 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 1925 | North Carolina 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 🕮 219-18-0731 86 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes XX No Maryland Harford Churchville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 3202 Churchville Road 21028 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 🔀 No Specify: White If Yes, Give Year or Dates: Specify: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Cashier Pharmacy 18. Mother's Name (First, Middle, Maiden Surname) Blanche L. Watson Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3202 Churchville Rd. Churchville, MD 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct.Date 1 20c. Location - City or Town, State 2011 Upper Cross Roads Cem. Baldwin, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service—BelAir Approximate Interval Between Onset and Death Bilateral Subdural 26 hours Hematonas Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of)

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other traument— and injury or other traument— Physician /Medi Exami

Physician

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Director

Funeral

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Division of Vital Records, P.O. Box 68760,

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	Medical Certification: To Be Completed by Physician/Medical Examiner

Funeral 1 Never Married 2 Married ģ 3 XWidowed 4 ☐ Divorced Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be Edmund Lovel ပု 19a. Informant's Name/Relationship (Type. Print) Michael D. Grogan / Son 20a. Method of Disposition 1 € Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximation of the disease of the disease of the death of the disease of the death of the disease o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is littled as a list of a little of a hat initiated events esulting in death) Last F FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 - Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in 1 Tes 2 → No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 | Natural 5 Pending investigation Fall from September 24201 1400 PM 1 ☐ Yes 2 ¥ No Standing position 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Paral Route Number, 4 Homicide City or Town, State) Cauch Ville Rel, Church ville 3202 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c. License number 9b. Signature and title of certifier Res - 000 September 76 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day,

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State c	of Marylar		artment of H tificate of L		Mental Hy	giene ₂	011	31229
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	edica mine:		4a. Facility Name (if not institution, DOCTORS COMMU)				4b. City, Town, or LANHAM	Location of Deat	- V V	4c. Co	ounty of Dea	
Fune Direct			5. Social Security Number 579-76-1845	6. Sex 1 X M 2 □ F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			9. Bii	rthplace (State or Foreign ountry) YLAND
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EBILIMOFE, IMARY/IBING 21213-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	Completed	- Complete	15. Deceder (Specify only higher Elementary/Seconday (0-12)	t's Education st grade completed) College (1		(Give k life. DC	ent's Usual Occup ind of work done of NOT use retired)	during most of wo	rking	İ	of Business	
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	sician/M		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live I	nant at time of o	al death 3	Ectopic pregnance Other (specify)	у		23d	d. Date of de Month	elivery Day Year
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Physician Physician this certifical al director	은	1	examiner? 1 Yes 2 No 27. Manner of Death		Inpatient 2 🗆		t 3 DOA Othe	er: 4 Nursing H	lome 5 ☐ Resi			cify)
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8		3	30. Name and address of person w		e of death (Item	23a) (Type, Pr	De De	ROAN !	hadusa	u, MB	207	06
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State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death erhardt Physician/ Month everly 35 pM Sept 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard columbia If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖳 F Month Day 927 219-46-7396 Washington, DC Director 64 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗶 No MD Howard Highland 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 13458 Villa D'Est Drive 20777 items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify. "natural", Completed 3 Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers of ပ Mary Fall Anthony Holmead permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13458 Villa D'Est Drive Highland, MD 20777 19a. Informant's Name/Relationship (Type, Print) Michael L. Gerhardt (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 9-27-2011 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funeral Servio 4 22. Name and Address of Facility Witzke Funeral Homes, Inc. Columbia, MD 21045 5555 Twin Knolls Road Part T. Efter the disc se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fine I Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) and I-transit Exami or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ρ Pregnant at time of death signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autonsy page 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 🗹 No Other: 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 욘 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🔲 Yes 2 🗆 No 1 Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 22 Sept 2011 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Humer Murah d 31. Date filed (IV State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11-07289 Ruthann Goodman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24H Hours N		•		Foreign	hplace (State or n
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	any	-	Usual Residence of Decedent 10a, State 10b, County	,	10c. City, Town	or Location	on						10d. Inside City Limits
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	Maryland 28a-f show d at once,	Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of Wha	at Coun	try?
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Ö	8 Camellia	Court			21234	ŀ				USA	
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	Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than njury or other traumatic event, the Medica		20a. Method of Disposition 1 Burial 2 X Crematic	on 3 Removal from S	state crema	tory or oth	tion (Name of ceme er place)	- 1	Date				Town, State
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	Balt Permit Depart Impor		21. Signature of Funeral Savic	e Lice see		22. N	ame and Address of RUCK TOV 1050 You	vson Fu	meral H	ome,	Inc.		
	Physician	-	23a. Part I. Enter the disease, of		ed the death. Do n	ot enter th	e mode of dying, s	uch as cardia	c or respiratory a	rrest, she	ock, or hea	nrt	Approximate Interval
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,	Division of Vital Records, P.O. Et al or Attending Physician: The law requires that the dra ster death. In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	P. P	Part II. Other significant cond	itions contributing to dea	ath but not resultir	ng in the ui	nderiying cause giv	/en in Part I.					ably 4 Unknown
	ords, w requires as been sig	Completed							24a. Wa				topsy findings available
	COC law r has b e 2 sho	ğ							per	opsy formed?	de	eath?	ompletion of cause of
	Vital Rec nysician: The l this certificate l director, page		25. Was case referred to medic	al			26.Place o	of Death (Che		2N	40	Ye	s 2 No
	Vita ysicia his cel direct	To Be	examiner? 1 ✔ Yes 2 No	Hospital: 1 Inpat	tient 2 ER/C	Outpatient	3 DOA	other Nu	sing Home 5	Reside	ence 6 🗸	Other:	Scene
ì	ing Ph		27. Manner of Death	28a. Date of Ir (Month, Day	njury 28b. ,Year)	Time of In		_	28d. Describe	e how inj	jury occurre	ed	
	ivisior or Attend after death. Director:	catic	_ J_ Fel	estigation fd 9-27		11:4	Opm 1 Ye	es 2 X No	unknow		and Numba	or Dur	ral Route Number, City
	Divi	Certification:	3 Suicide 6 X Col	uld not be ermined (Specify)	found a		-	naing, etc.		State)	8 Cam		ia Court
5	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil.		29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, de	ath occurr	ed at the time, date		and due to the ca	use(s) ar	nd manner		
	To the within To the complete	Medical		aminer: Dn the basis of ex		investigati	29c. License		at the time, dat				nth, Day, Year)
		2	29b. Signature and title of certif	A 5)/	1 A Doc	+	O.C.M				ptember		
			30. Name and address of person	on who completed cause of	death (Item 23a)								
1	D		Victor Weedn MD JD	Assistant Medic	al Examiner		. Baltimore St	reet, Baltir	nore, MD 212	223			
	0.1	ate	SEP 3 2011 ear	r) 32. Regut	rar's Standur	· Aller							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death P Fernber Physician/ 201 Medical Eacility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOPKINS timore 9. Birthplace (State or Foreign Country)
New_Jersey Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🏋 F Months Hours 8/18/1947 Director 166-38-8910 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NJWest Orange 1 Yes 2 X No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 07052 Funeral USA 40 Glen Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 72 hours after Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Specify: Year or Dates. mit. Page 1 and 2 should be filed within 72 hours bartment of Health and Mental Hygiene. bortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Artist 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Corrine Andrew Donald Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Moore Gaby-Son Glen Ave. West Orange, NJ 07052 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD 9/29/2011 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemt. 22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202 21. Signature of Funeral Service Lice Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ADENOCARCINOMA OF LUNG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Disk to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and I-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death signed by the a Unknown 9 Unknow Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 AProbably 4 ☐ Unknown 1 Yes 2 No been signature beautiful b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? page After this certificate 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending injury death. 1 Yes 2 No Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

SONJA SCHOLZ

31. Date filed (Month, Pay, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jana

600 N. Wolfe St. Balt-more MD 21287

SEPTEMBER

Registrar

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 31233 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25,2011 Month Physician/ 1:42 P M September Warren Franklin Goad Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 8012 Solley RD. Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral **Director** 218-40-9095 1 XM 2 □ F 68 Pennsylvania 2/24/1943 Usual Residence of Deced show or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Tes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or idical Examiner must be with t Funeral 21060 United States 8012 Solley Road 12. Was Decedent Ever in 1964 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceded 1904 Armed Forces? 1904 14 Yes 2 No 1968 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify. If Yes Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates er than "natura, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Electronic Elementary/Secondary (0-12) 12 College (1-4 or 5+) and Mental Hygiene. is marked other tha Data Processing ADP Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) ျှ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e Thelma M. Bisker Warren D. Goad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Severndale Road Severna Park, MD 21146 Mrs. Christina M. DeCosmo/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 09/30/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation MO1121|Service PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROBABLE MYOCARSIAL Phytician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? Natural 5 Pending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) d file of ertific 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

DHMH 17 Rev 06-2011

1406 SICRAIN HUY GLEN BURNIE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STELO6

2. Registrar's Sign

MRIOS D. 2168C

31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Oldio oi ivii	Ce	ertificate of	Death	Re	g. No. 0	31235
	Dhusisi		1. Decedent's Name (First, Middle, L	· _			2	2. Date of Death Month	Dav Year	3. Time of Death
	Physicia /Medic		Gloria M.	Hood				9	28 201	
	Examin	er	4a. Facility Name (If not institution, g				r Location of Death		4c. County of De	ath more
*	F		FRANKLIN SQUA 5. Social Security Number 6.		e (In yrs. last birthday		If Under 24 Hrs.	B. Date of Birth	9. B	irthplace (State or Foreign
	Funeral Director		090-18-5819	1 □ M 2 🖫 🕇	87 Yrs.	Months Days	Hours Min.	(Month, Day, Feb 2	0, 1924	New York
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	faryla f sho	5								1 □Yes 2 No
	the N	Director	MD Balt 10e. Street and Number	imore	Roseda	ale 10f. Zip Code		10	g. Citizen of What (Country?
	3a or		8525 Philadelr	hin Dood	Apt. 2	2123	37		United	States
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13		Hispanic Origin? (Spectan, Mexican, Puerto R	cify Yes or No-		nerican Indian,
21215-0036	I within 72 hours after death with the Maryland jeen. r than "natural", or items 23a or 28a-f show fro Middeal Exeminat must be redified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced		₩o	1 □Yes 2 □N6		iouri, otor,	Specify:	White
2-0	72 ho natur Jical	eted	15. Decedent's (Specify only highest of	Education	I (Giv	edent's Usual Occup e kind of work done	during most of working		6b. Kind of Busines	ss/Industry
121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5		DO NOT use retire	d)			
2	e filed w al Hygie other t vent, In		11 17. Father's Name (First, Middle, La	st)	Ma	achine Ope	erator 18. Mother's Name	(First, Middle, M	McCorm: laiden Surname)	ick
Maryland	e d to b	o Be	Alfred Renau				Agusta			
ary.	2 should be and Menta is marked aumatic ev	오	19a. Informant's Name/Relationship		19b. Mai	ling Address (Street	and Number or Rural		City or Town, State	e, Zip Code)
			Sharon Blum /	Daughter	8	525 Phila	delphia Ro	ad Apt.	2 Roseda	ale, MD 21237
ore	es 1 and 2 of Health f Item 27 i r other tra		20a. Method of Disposition 1 Burial 2 remation 3	□ Domoual from State	20b. Place of Disp cemetery, cre	oosition (Name of ematory or other pla	ce) Da		20c. Location - City	or Town, State
Baltimore,	permit. Pages 'Department of Important: If Ite any Injury or of Once.		4 □ Donation 5 □ Other (Spe	cify)	Chesap	eake Crem	atory	Sep 24, 2011	Beltsvi	lle, Maryland
Ball	permit Depart Import any In		21. Signature of Funeral Service Lic	ensee MOI	443		ion and Fune			
			23a, Part 1, Enter the disease, or co	mplications that caused	the death. Do not e					zyland 21286 Approximate
	Discoulation.		shock, or heart failure. List on immediate Cause (Final	ly one cause on each li	ne.	·		, ,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Se T	a consequence of:	CK				4 days
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587	rtificate ng phys as the	Medical		d						
Box (.E 5, €	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		П Б.A i			23d. Date of	delivery
	death ce	Physician/I	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown		B ☐ Ectopic pregnan □ Other (specify) _□	cy		Month	Day Year
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Records,	9 <u> </u>	Completed						24a. Was ar autops perforn	y prior	autopsy findings available to completion of cause of 1?
<u>a</u>	Iclan: The I certificate ha ector, page		25. Was case referred to medical				26. Place of Death		2 2 10 101	/es 2□No
Ξ	Physician: r this certific ral director, I	o Be	examiner? 1 Yes 2 No	Hospital:	ent 2 ☐ ER/Outpati	ent 3 DOA Ot	hor		ence 6 □Other (5	Specify)
ı of	ding Phy h. After this funeral c	n: To	27. Manner of Death	28a. Date of Inju		of 28c. Inju			ow injury occurred	роспу
<u>iō</u>	Attending r death. ector: Afte by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	on	19, 1041)		Yes 2 □ No			
-	= in the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Hornicide determine	a 126e. Place of III	jury - At home, farm, s c. <i>(Specify)</i>	street, factory, office	2	8f. Location (St. City or Town		Rural Route Number,
أست	Hospital (24 hours a Funeral Detely filled i	Č E		Physician: To the best						
	n 24 h	edical	(Check only 2 ☐ Medical Ex	amIner: On the basis of and manner st		investigation, in my	opinion, death occurre	ed at the time, d	ate and place, and	due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	1			nse number		9d. Date signed (M	
			Yuling	Zhang,	MD	D	70605		septemb	er, 28, 2011
	5		30. Name and address of person w	o completed cause of	death (Item 23a) (Type	e, Print)	uare Di	3 BOLT	omd	21237
	Sta	te	DR YULING Zh 31. Date filed (Month, Day, Year)	ang 90	rar's Signature	INCIN JQ	لالاالا كا			
	Registr		SEP 3 0 2011 A	wa A	rar's Signature					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State of M	•	partment of F e <i>rtificate of D</i>			giene 0 1	1 31236
Dhyainian		Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th	3. Time of Death
Physician Medica	1	Barney Harris				Sept	ember 29	2011 1:30 PM
Examine	r '	4a. Facility Name (if not institution, give street and number) Ardent Courts		4b. City, Town, or	Location of Death Pikesvi	110	4c. County o	f Death
Funeral			e (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
Director		215-18-5134 1 M 2 □ F	94 Yrs.	Months Days	Hours Min.	(Month, Day Sep 23	Year) , 1917	Country) Maryland
b w ti	- 1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
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21215-0036 within 72 hours after giene than "natural", o the Medical Exam ,	Completed	15. Decedent's Education	16a. De	cedent's Usual Occup	ation		16b. Kind of Bus	
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ould by mark mark		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street a	· · · · · ·			ate. Zip Code)
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of Hear	Ī	20a. Method of Disposition 1 □ Burial 2 ❤ Cremation 3 □ Removal from State		sposition (Name of rematory or other place	e) [Sep 30,	20c. Location - 0	City or Town, State
imc Page ment tant: I		4 ☐ Donation 5 ☐ Other (Specify)		ake Cremato	· i	2011	Belts	ville, Maryland
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	1443		n and Fune			
	\forall	23a. Part 1. Enter the disease, or complications that cause	d the death. Do not e					Approximate
~ Phylician/		shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition	es tia					Interval Between Onset and Death
Medical Examiner	1	a.	a consequence of):					70-02
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P.O. Box that the death c ned by the atten e detached for u) A	1 Yes 2 No 4 Pregnant a 9 Unknown	at time of death	o □ Other (specify) _				
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ital sician certifi rector	Ď	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 I I I I I I I I I I I I I I I I I I		Oth	ace of Death (Checker:			Annie III
Of V	2	27. Manner of Death 28a. Date of inju	ient 2 ER/Outpa ury 28b. Time	of 28c. Injury	4 □ Nursing Ho / at		ence 6 Other ow injury occurred	(Specify) /Sixted Wind
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Division of Vital Records, all or Attending Physician: The law requires s after death. In Director. After this certificate has been signed in by the funeral director, page 2 should be	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injuding, et	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S City or Tow		or Rural Route Number,
Dipital of points a erral Diffiled i		29a. Certifier 1 Certifying Physician: To the best o	my knowledge, dea	th occured at the time	date and place an	d due to the ca	see/e) and manner	r ac ctated
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examiner: On the basis of a only one) 3 Certifying Nurse Practioner; To the	examination and/or in	estigation, in my opinio	on, death occurred at	the time, date a	nd place, and due	to the cause(s) and manner stated.
To th To th comp		29b. Signature and title of certifier		29c. License			-	(Month, Day, Year)
		Jeran (Sad und)		DO	061199		sept,	30,2011 mp21204
10		30. Name and address of person who completed cause of o	leath (Item 23a) (Type	e, Print)	(,,,,	4105	Talle	11.201204
State		Jason Blackmb 6701 31. Date filed (Month, Day, Year) 32. Regist	ar's Signature	arres 31	, JUINC	1103	106500	1 100 2 1207
Registra		SEP 3 0 2011 Seren > 3.	ar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September ^D27,2011 Physician/ John Clark Hagan, Sr. 5:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore 9. Birthplace (State or Foreign . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 219-30-6331 1**X** M 2 □ F 77 Director Baltimore, MD 1934 Sept. 4, 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Millers notified MD Carroll 1 Yes 2 X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? must be 21102 23a Funeral 3922 Church Road United States or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 【X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White "natural", Completed 3 ₩ Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) Univac Company College (1-4 or 5+) the Computer Specialist other traumatic event, Be filed) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche Stansbury John George Hagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is r 1397 Macton Road, Street, Maryland 21154 Michael P. Hagan- Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 1 Burial 2 Cremation 3 Removal from State Hother place) Baltimore, Maryland Memorial Gardens 01, 2011 4 ☐ Donation 5 ☐ Other (Specify) Evans Fureral Chapel & 3 Newport Drive 21. Sign ture of Funeral Service Licenses Cremation Services Hill, Maryland 21050 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 No certificate 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 when (Specify) 1 Yes 2 X No 욘 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpa within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month) Dw.

N. Charles

ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street 4b. City, Town, or Location of Death **Examiner** and number) County of Death If Unde If Under 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1. M 2 □ F Months Hours Min 06/18/1955 Country)
Maryland 213-58-9236 Director 56 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director Maryland Prince George's Laurel 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20708 11696 S. Laurel Drive #1B USA 11 Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc Completed by 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 Yes 2X No Black Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Groundsman Supervisor Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Florence Chapman Ernest Spriggs, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11696 S. Laurel Drive #1B, Laurel MD 20708 Vineca Faye Harrison (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 10/7/2011 Laurel, Maryland 21. Sig viture of Funeral Service Licenses 22. Name and Address of Facility Latimore Funeral Services, P.A. 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 0 Physician/ ON disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☐ No Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
2 Accident
3 Suicide 5 Pendina 1 🗌 Yes 2 \square No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 2104 059

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien U State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2035 HAHN PM ILLIAN 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 M 2 X Days (Month, Day, Year) Months Hours Min. Balto, MD 236-80-5453 63 Director 22-1948 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 □ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10840 Apt#2 Downsville Pike 21740 USA death \ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 72 hours after Yes, Give 1 ☐ Yes 2 😾 No Specify: Specify: White "natural" 3 Widowed 4 X Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Elder Care is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Leonard Heflin, Sr. Tharon Rosalee Henretta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health a Important: If item 27 is any injury or other trau 99 Rawhide Dr., Bunker Hill, WV 25401 Ernest Leonard Heflin, Jr/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/21/2011 | Martinsburg, WV Rosedale Cemetery Signature of Funcing Service Licensee Vernon R. Lohn II 12. Name and Address of Facility Miller Dippel Funeral Home Lic# M01537 6415 Belair Rd.; Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ GASTRO INTESTINAL BLEED SECONDARY TO VARICES disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner LIVER FAILURE RENAL PAILURE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami RESPIRATORY FAILURE The law requires that the death certificate be executed Cause (Disease or iinjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical SEPSIS Box 68760 the as nse es, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 5 Other (specify) Month Day P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ျ 1 💢 Inpatient 2 🗌 ER/Outpatient 3 🗓 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 X Natural 5 Pending work 1 ☐ Yes 2 ☐ No neral Director: A I filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner on the basis examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie Date signed (Month, Day, Year who completed cause of death (Item 23a) (Type, Print) and address UNIVERSITY OF MARYLAND - 22 SOUTH GREENS ST, BALTIMORE 21201 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28 Month Physician/ 3:50 P M Carol Huddleston 2011 Wanda September Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Harford Bel Air <u>Upper Chesapeake Medical Center</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Yea 1 🗆 M 2 🛛 F Months Days Hours Maryland **1**950 Director 212-56-6840 Jan. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director traumatic event, the Medical Examiner must be notified 1 Yes 2 X No Maryland Harford Edgewood 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a U.S.A. 21040 304 Bauers Dr. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home llth. Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked c ပ Dugger Coleman Nancy Herman is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important. If item 27 is any injury or other tra Edgewood MD 21040 Floyd Huddleston/Husband 304 Bauers Dr., 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/1/2011 Holly Hill Mem. Gardens Baltimore 22. Name and Address of Facility
Miller-Dippel Funeral Home, 21. Signature of Funeral Service Licensee 切り <u>6415 Belair Road Baltimore</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or impury Examine Due to (or as a consequence of): ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Day Year Month Pregnant at time of death 2 🗌 No 1 Yes 2 9 Unknown cate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 0136 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 180037 examiner? Hospital: Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of To the Hospital or Attending F Within 24 hours after death. 1 Natural (Month, Day, Year) 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1🚅 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0036487 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Bei Air, MD 21014 500 Upper Chesapeake 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 31241 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPT. 2011 28 7:00A Paul Harold Hardy, Jr. Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 11630 Glen Arm Road Glen Arm 8. Date of Birth 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours North Carolina 06/10/1916 **Director** 225-01-5817 1 X M 2 □ F 95 Usual Residence of Decede ms 23a or 28a-f shov must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 X No MD Baltimore Glen Arm 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 11630 Glen Arm Road - Apt. L44 21057 ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates. WW II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 10 Research Microbiologist Johns Hopkins Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Laura (unknown) Paul Harold Hardy, Sr. and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11737 Glen Arm Road - Glen Arm, Maryland 21057 Janet H. Thayer (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 09/30/2011 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-trans that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 2 🗌 No certificate Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Af
ed in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined City or Town, State) within 24 hours a To the Funeral D Medical Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie and address of person who completed cause of de ath (Item 23a) (Type, Print) 6701 CASM (31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

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State of Maryland / Department of Health and Mental Hygiene 20 | 1 3 | 2 4 2

Displace Continue			1- For State Registrar		Cer	tificate o	Death				Reg. No) .			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5, per inf, 921, 11-7-11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ATHERINE 8:05 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ARBOR HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Hours (Month, Day, Year) 12/03/1925 85 **Director** Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State the Medical Examiner must be notified at Director N/A **Baltimore** Maryland 1 X Yes 2 No 10e. Street and Number 10f, Zip Code o 10a Citizen of What Country? Funeral 23a U.S. 3816 Leadenhall Street 21225 or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black White, etc. 1 Never Married 2 Married 1 Yes 2 X No þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: and Mental Hygiene. is marked other than "natural", White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 3rd College (1-4 or 5+) Quality Control Glass Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be John William Reel Mabel Irene Row 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Dorothy Gordon / Daughter 3816 Leadenhall Street Baltimore, Maryland 21225 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State MD State Veteran Cem. 09/29/2011 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatur of Funeral Service Liberisee namuelle 4001 Ritchie Highway Baltimore, Maryland 21225 23a. art 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT Ph sician/ disease or condition resulting in death) Medical **Examiner** RESPIRATORY FAILURE Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 phys. as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Por Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 1 9 Unknown per a | Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MILLETUS HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed , DYSLIPIDEMIA, AORTIC STENOS 244. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 Jas page 2 s 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28h Time of 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioners To the best of my knowledge persured at the time, date and black and due to the newselst and persur as state 29b. Signature and the of confier 29c. License number 29d. Date signed (Month, Day, Year) RES-001 SEPTEMBER 25, 2011 OUSTIN SKWERES MD BALTIMORE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARBOR HOSPITAL 3001 SOUTH HANOUER JUSTIN SKWERES MD 2112 31. Date filed (Month Dec. Year) State Registrar

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State of Maryland / Department of Health and Mental Hygiene 2011 31244

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Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223				Panelly	10 -01			07.			U.U.IVI	I.C.				pterriber	24, 2011	_	
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 28, 2011 Barbara L. 10:20 A M Hartka Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min 217-38-4736 11/25/1942 **Director** 68 Maryland 1 M 2 XF Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Phoenix 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 21131 U.S.A. 16 Glenbrook Drrive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 X Married ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Eugene Barni Marian Barbara Koch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. 16 Glenbrook Drive Phoenix, Maryland 21131 Theodore Hartka / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 10/1/2011 Hydes, Maryland John Cath.Ch.Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph. i i n disease or condition resulting in death) BREAST CANCER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ģ Month Day Year Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 🔲 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes Hospital or Attending Physician: The Yes 2 X No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: မ 1 🗌 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pendina s after death. I Director; Af Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 20 who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State Registrar

10:20

SEPTEMBER 28

BARBARA HARTKA

		•	For State Registrar	(State of N	/laryland		artment <i>tificat</i> e			and M	lental Hy	giene	$Z \cup I$		3 1	246
	Physicia		1. Decedent's Name (First, M HOWARD	ddle, Last) LEE	HI	CKEY						2. Date of De	eath		Year 0 1		e of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number) STELLA MARIS HOSPICE					4b. City, Town, or Location of Death TIMONIUM					4c. County of Death BALTIMORE				
	Funeral Director		5. Social Security Number 212-28-8087	6. Sex	M 2 □ F 7. A	.ge (In yrs. las 81		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da 8 - 2 3		30 1	9. Birthp		te or Foreign
Maryland 21215-0036	ryland -f show ied at	ctor	Usual Residence of Deceden 10a. State 10b. Con		IMORE	10c. City,	, Town or Loc		RRY	HAI	L				1		e City Limits
	th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 4937 MARCH	-			10f. Zip Code 21128						1 Yes 2 XNo itizen of What Country?				
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ह्य	11. Marital Status 1 ☐ Never Married 2 🖔 3 ☐ Widowed 4 ☐ Divo	12.	Was Deceden Armed Forces Wayes 2 [If Yes, Give Year or Dates.	? □ No	_ _ 1		nt of His y Cubar	spanic Orio n, Mexican		cify Yes or No- Rican, etc.)	-	14. Race	- Americ , White, e		,
	within 72 hou giene. er than "nat , the Medica	Completed	15. Dec (Specify only f Elementary/Seconday (0-		(Give A			ent's Usual kind of work D NOT use r RANSP	uring most		ing	16b. Kind of Business Industry BALTIMORE COUNTY PUBLIC SCHOOLS					
/land	d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Midd JOSEPH	lle, Last)		HICK	ΈY				er's Name LLIA	e (First, Middle N	, Maiden		HEEL	ER)
Man	d 2 should alth and M 27 is ma er trauma		19a. Informant's Name/Relat EILEEN A. H	onship <i>(Type,</i> [CKEY/	Print) WIFE		19b. Mailin 4937	g Address (MARC	Street a	nd Numbe	er or Rura	Route Number	er, City o RRY	r Town, Sta HALI	ate, Zip C	Code) ID	21128
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition 1 A Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth		moval from Stat	- Ce	ace of Dispo metery, crem RED H	natory or oth	er place	sus		Date 9 – 11	1	ocation - 0	-		e
Balti			21. Signature of Funeral Serv	ce Licensee	S	5				s of Facilit		CH/ROS		ALE I	FUNE MD		HOME 237
	hysician/ Medical Examiner	er	23a. Part 1. Enter the diseas shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	ist only one ca	CHRONI (Due to (or a	ne.	RUCTIV						rrest,				mate Between nd Death
09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, lead of Limbertian cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of):													
. Box 687		Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery Month Day Year						
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Records,	The law requate has been page 2 shoul	Complete										24a. Was auto perfe 1 \square Yes	psy ormed?	pr de		npletion	gs available of cause of
Vital	nysician: nis certific director,	To Be	25. Was case referred to med examiner? 1 Yes 2 No	cal Hos		itient 2 🗆 E	R/Outpatien	t 3 🗆 DOA	Other	ce of Deat		only one) me 5 ☐ Resi	idence	6 X Other	(Specify)	HOS	PICE
Division of Vital	Hospital or Attending Pl 24 hours after death. Funeral Director: After th eted filled in by the funeral	Certificate:	3 Suicide 6 Co	nding estigation	28a. Date of in (Month, D	ay, Year)	28b. Time of injury ne, farm, stre	М			No	28d. Describe 28f. Location (City or To	Street ar	nd Number		Route Nu	umber,
Οj		Medical C	(Check 2 Medie	al Examiner:	n: To the best of On the basis of ractioner: To the	of my knowle	and/or invest	igation, in m	y opinior	n, death oc	curred at	d due to the ca	ause(s) a	nd manner	to the cau	ise(s) and	l manner state
	To the within To the comp	2	29b. Signature and title of con		W.P	o best of my	Kilowiedge, C			number	Z	e, and due to t		atersigned			
10	Y		30. Name and address of per JACKIE JONES			,	23a) (Type, P EY VAL	,	D.	TIMO	NIUM	, MD 2	1093	-			
	Stat Registra	-	31. Date filed (Month, Day, Ye. SEP 3 0 201	ar)	32 Regie	trar's Signatu	ire										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:35 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore billitation and Year If Under 24 Hrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) 216-36-2177 Director 1 □ M 2**X**] F 1-5-1940 Maryland 28a-f show 10b. County 10d. Inside City Limits Examiner must be notified at 10c, City, Town or Location Director 1 Yes 2 No Maryland Anne Arundel Pasadena ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 21122 436 Maryland Ave within 72 hours after death tems 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White "natural", 3 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Food 8 Packaging Associate Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ Rebhan Mary G. Vernon James Hood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra 436 Maryland Ave Pasadena, MD 21122 Mrs. Mary D. Harris/ Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept Date 30 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Glen Burnie, MD Glen Haven MEM. Park 22. Name and Address of Facility Singleton Funeral Cremation 21. Signature of Funeral Service Licer Services PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician SCKro disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed -trar and resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ed by the a 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an After this certificate has autopsy performe death? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2. No 욘 1 Yes ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 1/A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 31. Date filed (Month Day, 32. Registrar's State Registrar

DHMH 17 Rev 06-2011

11-07216 Noreen Jeter Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 3 | 2 4 | 3 | 2 | 4 |

		1- For State Registrar	Cer	tificate of	Death		R	eg. No.	_			
Physici		Decedent's Name (First, Middle,Last)							3 Time of Death			
edical Exami	iner	NOREEN JETER 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death						Month Day Year September 24, 2011 2337 hrs				
		4a. Facility Name (if not institution, give st Civista Medical Center	reet and number)	4	b. City, Town, o La Plata	or Location of L	Jeath	4c. County of D Charles	eatn			
Eurosal		Social Security Number 6. Sex	7 Age (In vrs. la	est hirthday)	If Under 1 Ye	ar If Under 2	24Hrs. 8. Date of Bi		. Birthplace (State or			
Funeral Director	217-72-4735 1 M 2 X F 51 Yrs. Months Days Hours Min. 11/28/1959							lF(Birthplace (State or preign WASHINGTON Country) DC			
, fa	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Location	on				10d. Inside City Limits			
T MOI S		MADVIAND CHADIES WAIDORE										
Maryland 28a-f show any d at once.		10e. Street and Number	**	ALDORI	10f. Zip Code		1	log. Citizen of What	Country?			
the Ma is or 28	Director	4561 GROUSE PLACE				0603		UNITED	STATES			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Headland and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.S Armed Forces?				? (Specify Yes or No uerto Rican, etc.)	o- 14. Race - A White, e	merican Indian, Black, tc.			
ther d		3 Widowed 4 Divorced If	Yes, Give Year	1	Yes 2X N	o specify:		Specify: BI	LACK			
ours a	d by	15. Decedent's Education (Specify only	Dates: highest grade completed)		s Usual Occup			16b. Kind of Busin	ess/Industry			
6 172 h cal Ea	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)					77.77.77	A TOTAL			
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21215-0036 build be filed within 7 Mental Hygiene. marked other than ic event, the Medical		17. Father's Name (First, Middle, Last)	IETED			18.Mothers I	Name (First, Middle,	FITZPATR	I CK			
212 ald be Menta mark	o Be	SPENCER D. 19a. Informant's Name/Relationship (Type	JETER	19b. Mailing	Address (Stre			mber, City or Town, S				
MD and 2 show alth and m 27 is aumatic	_	DELONTE JETER / SOI						MARYLAND 2				
e, No. 1 and Health		20a. Method of Disposition		Place of Disposit		emetery,	Date	20c. Location - Cit	y or Town, State			
nor rages art of other		1 X Burial 2 Cremation 3	Itellioval Ilolli State	URRECTI		TERY	10/06/201	LANDOVE	R, MARYLAND			
Baltimore, ormit. Pages I an Department of Hea Important: If item injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee							HOME, INC.			
		Dauchmell M. Co	grallly	747	4 LANDO	VER RO	AD, HYATT	SVILLE, M	20785			
Physician		23a. Part le Enter the disease, or complica failure. List only one cause on each	tions that caused the death. line.	Do not enter the	e mode of dying	g, such as card	diac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and			
/Medical Examiner		Immediate Cause (Final disease a. Int	racerebellar Hemorrh		ating Hype	rtensive Ca	ardiovascular Di	sease	Death			
		or condition resulting in death) Due to (or as a consequence of):										
	e	Sequentially list conditions, if any, leading to immediate but to (or as a consequence of).										
	Ë	cause. Enter Underlying Cause										
led nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):										
760, icate be executed physician and the burial - transit		d. UNPENDED AMENDED										
' 60, ate be physici he buri	Medical		23c. If yes, outcome of pregn	nancy				23d. Date of del	ivery			
687 ertifica ding p	-	23h Was decadent progrant in the	1 Live birth Pregnant at time of dea	2 Feta	al death 3	Ectopic p	regnancy	Month	Day Year			
Box 687 death certific the attending of	Physician	1 Yes 2 No 9 V Unknown										
by the by the ched f	Ph		9 Unknown ntributing to death but not re	sulting in the ur	nderlying cause	given in Part	I. 23e. Did t	obacco use contribut	e to the cause of death?			
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach.	Š						1Ye	s 2 No 3	Probably 4 🗸 Unknown			
Division of Vital Records, tal or Attending Physician: The law require is after death. al Director: After this certificate has been sited in by the funeral director, page 2 should b	Completed						24a. Was		e autopsy findings available			
e law e has be se 2 sh	ш							ormed? deat				
Retificat		25. Was case referred to medical			26 Plac	ce of Death (C	heck only one)	2 No 1	Yes 2 No			
/ita	o Be		oital: 1 Inpatient 2 ✓	ER/Outpatient				Residence 6	Other:			
of \officers	-	27. Manner of Death	28a. Date of Injury	28b. Time of In	jury 28c. Inj	ury at Work?		how injury occurred				
or: A	ţį	1 Watural 5 Pending (Month, Day, Year) 1 Yes 2 No										
ViSi or Att fter de Direct in by	ifica	2 Accident Investigation 3 Suicide 6 Could not be		28f. Location (Street and Number or Rural Route Number, City								
Division of population or Attending Phous after death. Peral Director: After tiffled in by the funeral	Certification:	4 Homicide determined (Specify) or Town, State)										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Foureral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.												
To the Comp	Medical	2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye										
	29b. Signature and title of certifier 29c. License number O.C. M.E.							September 25, 2011				
Ye no Olt ANNIHAM (1, 1811)												
8			ssistant Medical Exar		W. Baltimo	re Street. E	Baltimore, MD 2	1223				
	ate	31. Date filed (Month, Day Year) 201	32. Fegistrar's Signatur		red							
Regis		SEP 3 U 201	11 (buena)	a. Da	1000							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 Year Aileen Reese Johnson Sept. 16:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Gilchrist Hospice Columbia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day,
June 30 9. Birthplace (State or Foreign Country) Georgia 7. Age (In yrs. last birthday) Funeral Hours 1 M 2 X F 90 Months Days 217-58-4776 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location at 10a. State 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Howard Columbia () 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21045 9210 Perfect Hour permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White nan "natural", Medical Exan 1 Yes 2 X No Specify: 3 - Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) l Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the I Cashier Clerk Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Waldo Newton Ila Ree Usher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9210 Perfect Hour, Columbia, Maryland 21045 Cecilia A. Johnson - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important; If it any injury or o once. 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Little", frematory or other place) BC 09/28/2011 Rocky Ford, Georgia 21. Sigr Witzke Funeral Homes, Inc. ture | f Funeral Service 22. Name and Address of Facility 5555 Twin Knolls Road, Columbia, MD 21045 MO1283 Part 1. Inter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ EMPHUSEMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 🕱 No Pregnant at time of death 1 Yes 2 7 q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CERVICAL DYSTONIA 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2X No ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier SEPTEMBER 22, 2011 264395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA, MD 21044 FEDAR LANE DOBERMAN, MD 6336 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 0 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 09 Month 2011 9:55 РМ 26 Physician/ MYRTLE ALICE KRAFT Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Arundel Severna Park Anne Genesis Severna Park Center g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Days **Funeral** Hours O'Month Day, Country) Months 1 🗆 M 2 🔀 F MD 216 20 3037 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 X No Pasadena Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Funeral 21122 8438 Park Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 X No Yes, Give þ 1 Never Married 2 Married be filed within 72 hours after 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 12 Own Home Home maker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Myrtle Helen Jefferson ပ Anderson Moore, Sr. James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) and lis ma 21122 Pasadena, 8438 Park Rd Cheryl Woolford - daughter Health tem 27 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State Meadowridge Mem Pk 9/30/11 Elkridge, 4 Donation 5 Other (Specify) 22. Name and Address of Facility GJ Gonce Funeral Home Signature of Funeral Source Licensee 169 Riviera Drive Pasadena, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final JARCONENIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death Year Month in the past 12 months?
1 Yes 2 No Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached filled in by the funeral director, page 2 should be detached filled. g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2- No 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: **1** ≥ Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Russell Deluca,

3

MD

Baltimore, Maryland 21215-0036

305 Hospital Drive

Glen Burnie,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien? State Registrar Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ LEE GARY SEPTEMBER 2011 48 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death County of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1963 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 X M 2 🗆 F 48 AUGUST WASHINGTON, DC 579-96-3375 **Director** Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 ☐ No PRINCE GEORGE'S MD BOWIE 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 911 PLEASANT HILL LANE USA 20716 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 0 1X Never Married 2 Married 2 X No Completed by 1 Yes If Yes, Give Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) FORK LIFT OPERATOR PRIVATE 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ALICE PARKER JAMES EARL LEE and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 511 SHADY GLEN DRIVE CAPITOL HEIGHTS, MARYLAND 20743 Health a ALICE LEE/MOTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 9/29/2011 ADELPHIA, MARYLAND WASHINGTON NATIONAL 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licens 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ch line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not soulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: <u>ام</u> 1 🗌 Yes 2 3 🕅 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury fter death. 1 🔲 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined within 24 hours

To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 20785 HOSPIAL DRIVE CHEVERLY, DEMETRIOS CATEVENIS M.D. 3001 31. Date filed (Month, Day Year) -32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death City, Town, or Location of Death **Examiner** NNA WNE If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. (Month, Day, Year) 024-18-8914 88 Director 1 M 2 XF 1923 Massachusetts June 14, Usual Residence of Deceder 28a-f show 10a. State 10c. City, Town or Location 'natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 931 Riverside Cir death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 2 Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 XDivorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha the real estate broker real estate 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lucy Smalley John Mason Duggan Department of Health and Important: If item 27 is n any injury or other traumone. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore J. Martens, Jr-son 3509 So. River Terrace; Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 Other (Specify) Ronal de S 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21014 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, wheart failure. List only one cause on each line nterval Between Qnset and Death Immediate Cause (Final Ph_sician/ MULTIGREAN disease or condition resulting in death) FOULR 140005 Medical Due to (or as a consequence of) Examiner ARDIO- PUL MONNET HOURS Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Completed by Physician/Medical P.O. Box 68760 as the attending IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cardiogenic shock Records, 1 Yes 2 No 3 Probably 4 Vnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performed 2 🗌 No Yes 2 No 1 Yes Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital ၉ 1 🗌 Yes 2 X10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Accident 5 Pending М Investigation 24 hours after death Funeral Director: the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the I 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and little of certifier 29c. License number 72/94 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanak Ramesh Patel Anne Arundel Medical Center Annapolis, MD 21401 31. Date filed (Month, Day Year) - - - -State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 0 1 1 3 1 2 5 3

Pedro Antonio Sa		ia-Marchante I- For State Registrar	State	of Maryla		oartment e <i>rtificate</i>			and Ment	al Hy		Reg. No	o.	•	
Physiciar Medical Examin	1/	Decedent's Name (First, M	ddle,Last	PEDRO	ANTONI	O SARA	AVI	A MARC	HANTE		Date of De Month Septemb		Year 5, 2011	(3. Time of Death 1325 hrs
		4a. Facility Name (if not instit 4915 LaSalle Road	ution, give	street and nur	mber)		4	b. City, Town, Hyattsvill	, or Location o	f Death		ľ	4c. County of I Prince Ge		S
Funeral Director		5. Social Security Number 577-27-7253	6. Se		7. Age (In yrs	i. last birthday		If Under 1 Y	Year If Under Days Hours	_	8. Date of E July 3	,	10	oroian	place (State or ntr F 1 Sa1vad
ne Maryland or 28a-f show any fied at once.		Usual Residence of Deceden 10a. State 10b. Cour DC				ty, Town or Lo ASHINGT		, DC							10d. Inside City Limits 1 X Yes 2 No
the Mary	9	10e. Street and Number	REET	NE				10f. Zip Code 20018				-	itizen of What Salvad		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland hant: Uften 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	- L	11. Marital Status 1 Never Married 2 X	Married	12. Was Dece Armed For 1 Yes If Yes, Give Year or Dates:	rces? 2 No		If Ye	Decedent of s, specify Cul	Hispanic Origi ban, Mexican, No specify:	Puerto R	ican, etc.)	10-		America etc.	an Indian, Black,
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		-	State Registrar	olato ol Marylano	Cer	tificate of E	Death		Reg. No.	
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	r iten iner r		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	I ☐ Yes 2 ☒ No	Specify:		Specify:	White
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Baltimore,	nt of h		1 🛛 Burial 2 ☐ Cremation 3 ☐	Removal from State cer	netery, cren	sition (Name of natory or other plac	, ,	I	20c. Location - Cit	·
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	5		39 Name and address of person who d	ompleted cause of death (Item 2	E S (Iype, F	DEFEN	ISE HW	M, An	WAPOLI :	10715-P-51401
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Messenger MAURICE 2011 0430A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1229 Wall Street BALTIMORE 8. Date of Birth
(Month, Day, Year)
121 5. Social Security Number 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** 1 **M** M 2 □ F 90 Hours 218-10-3570 **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Famt: If item 27 is marked other than "natural", or items 23a or 28a-f show lary or indems 27 is marked other than "natural", or or items be notified at iny or other traunatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Maryland N/A Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21230 USA 1229 Wall Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Education Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sterling Messenger Mvrt1e Hanlev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21230 Department of Health Important: If item 27 any injury or other tr 1229 Wall Street, Baltimore, Anna Messenger (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 2011 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licasses 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suse on each line. 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one complications. Approximate Interval Between Onset and Death Immediate Cause (Final StagE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Demen Vascular 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 M ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 PNo Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

 Medical Examiner: On the basis of examination and/or investigation, in my calcium, death assumed to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Registrar

Baltimore mo 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3 | 256 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 6505 Armstrong Social Security Number 6. Sex Baltimor 8. Date of Birth (Month, Day, 03 31 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral Days Months Min 1 □ M 2 🂢 F Hours 96 217-22-2036 Director ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MID NA Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6505 Armstrong 21215 U.S.A. "natural", or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 **X**No Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade Domestic Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert T. Alexander Kate Baskerville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 North Woodson Road, Herbert Alexander-Son Baltimore, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Maryland National 10/5/2011 Laurel, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Av of Juneral Service Licenses Ave. Baltimore, Md Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Imme The Cause (Final disease or condition Onset and Death Physician/ 4 Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir attending physician and I for use as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) been signed by the atte should be detached for in the past 12 months? Dav Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 No 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred **U** Natural 5 Pending injury work? 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3
Certifying Nurse Practioner: only one To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

State

Date filed (Month, Day,

ne and address of person who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GEORGE ROBERT MORAN JR. SEPTEMBER 23 Year 2011 3:27a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 8176 GRAY HAVEN ROAD DUNDALK BALTIMORE . Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 XM 2 F Months Hours 70 0 77 77 79 19 41 214 38 1474 **Director** MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 🗆 Yes 2 ื No MD BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8176 GRAY HAVEN ROAD USA 21222 filed within 72 hours after death 11 Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ROOFING ROOFER 27 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental **GEORGE** ROBERT MORAN SR. RUTH MILDRED McCORMICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA R. MORAN/WIFE 8176 GRAY HAVEN ROAD DUNDALK, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9-27-2011|BALTIMORE, MD METRO CREMATORY 4 Donation 5 Other (Specify) 21. Signature of Funeral Se vice Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown ate has been signed by the a page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? After this certificate 1 Yes 2. No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d, Date signed (Month, Day, Year)

Registrar

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State

31. Date filed (Month, Day, Year)

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on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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State Registrar

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John AllEN Re 31. Date filed (Month, Day, Year) SEP 3 0 2011

ted cause of death (Ism 23a) (Type, Print) 4 EAST ROlling Cross

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September C S& Soll Physician/ Frank 3:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Augsburg Lutheran Home Baltimore County Lochearn If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 053-10-4913
Usual Residence of Decedent **Director** 1 **X** M 2 □ F 99 5/24/1912 New York 28a-f shov 10a State 10b. County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director MD Baltimore Lochearn 1 Yes 2 XNo ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21207 6811 Campfield USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0, Completed by 1 ☐ Yes 2 🛭 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White "natural", 3 XWidowed 4 Divorced Specify: Year or Dates Medical 15. Decedent's Education 16b. Kind of Business/Industry NY 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megonee. Elementary/Secondary (0-12) Transit Authority College (1-4 or 5+) Trackman N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maria Ricardo Joseph Modica 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arline M. Schoenberger Sparrows Ridge Glen Mills, PA 19342 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pineline Mem. Park10/3/2011 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Pineline, NY 4 ☐ Donation 5 ☐ Other (Specify) Thomas Signature of Funeral Service Licensee 22. Name and Address of Facility F. Dalton F/H 125 Hillside Ave. NewHyde Pk, NY 11040 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Stage Cardiovascular disease or condition resulting in death) Medical Due to (or as a consulence of) Examiner Sequentially list conditions, Examine If any, leading to homedis cause. Enter Underlying Directo for es e nor secular ne gri or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 attending p IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year signed by the at d be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature of A 29d. Date signed (Month. Dav. Year) Sentember 29 2011 D002333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultrine Mdzizo4 100 58 Sm 31. Date filed (Month, Day, Year) Registrar's Signature State 30 Registrar

State of Maryland / Department of Health and Mental Hygien 20 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ana Josefa Vargas Mel**end**ez September 2011 8:12 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 081 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Hours El Salvador 94 Director <u>577–66–8568</u> February Usual Residence of Deceden "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 90 Monroe Street, Apt # 805 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 🛚 Yes 2 □ No Specify: Salvadoran Completed 3 👿 Widowed 4 🗆 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. the Own Home Homemaker other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည should be Jose Vargas Marina Melendez f Health and T is meretain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Malhotra / Daughter 3672 Ridgeview Road, Ijamsville, Maryland 21754 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Montgomery Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State September 4 Donation 5 Other (Specify) 29, Bethesda, Maryland 2011 21. Signure and September 1. Signure 1. Sign 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, In
Rockville, Maryland 20850 M01619 300 West Montgomery Avenue, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardia disease or condition Medical resulting in death) Examiner roscleratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 ponth

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy be detached for Month Year Pregnant at time of death Day g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ĝ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA eral Director: After thi filled in by the funeral . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 258025 Deptember me and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Cir Dr Rochville MD Jonathan MD wenk 31. Date filed (Month, Day, Year) **SEP 3 0 2011** 32. Registrar's State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. 3 State of Maryland / Department of Health and Mental Hygierie Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MULLENA K 7011 0718 MILLIS . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Days Hours West Virginia 1 (9°21 Pay 1 9°23 87 287-16-8301 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f shor 10c. City, Town or Location event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🏝 No Severna Park MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a United States 206 Baltimore Annapolis Boulevard 21146 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces?

TYPYes 2 No 1943—
If Yes, Give
Year or Dates. 1946 Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ь by 1 Never Married 2XXMarried Maryland 21215-0036 1 Yes 2 X No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Utility Man Truck Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ٥ Ina Cloe Myers Floyd Willis Mullenax permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21146 206 Baltimore Annapolis Blvd., Severna Park, MD Betty Mullenax - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, XXXBurial 2 Cremation 3 Removal from State Meadowridge Mem. Prk. 09-26-2011 Elkridge, Maryland 4 Doyalon 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Signature of Funeral Service License Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that cause shock, or hear failure. List only one cause on each death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Dunth Immediate Cause Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DISEASE ARKINSON sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner em AtomA Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) ıding physi**ci**an Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 50H 2 No 3 □ Probably 4 □ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No (CH 24a Was an autopsy performed certificate 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred fell down Stepsettome un we tuen 5 Pending DO W Natural 312011 Accident 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number 4 Momicide determined Baltinue A NNAPULIS BUIS Home 206 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifi 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 15+1 EFENSE HWY in 441 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dolores A. Neas 3 40 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Rose dale Baltimore HOSPIT 8. Date of Birth 7. Age (In yrs. last birthday) 82 Yrs. If Under 1 Year If Under 24 Hrs 5. Social Security Number 217-24-4394 **Funeral** g. Birthplace (State or Foreign 1 M 2 X Year) 929 Dayton, Ohio Director Mar. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. Count Director 10c. City, Town or Location 10d. Inside City Limits Baltimore MD Perry Hall 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9501 D Kingscroft Terrace 21128 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) Page 1 and 2 should be filed within College (1-4 or 5+) Own Home 12 Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last)
Walter Darmody Maryland 18. Mother's Name (First, Middle, Maiden Surname) မ Theresa Maloney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300~Winston~Ave.~Wilmington,~DE~19804permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Karen Stone- Daughter 20a. Method of Disposition cemetery, crematory or other place)
Parkwood Cemetery 3, 2011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 2 a. P rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In m diate Cause (Final Ph sician/ End d e e or condition resilting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and deelached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months? Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Tyes Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed course of death (Item 23a) (Type, Print) tramtun 9000 Franklin Square Drive 31. Date filed (Month Paye Year State

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Registrar

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amend items 23a pt 11 24a b per library and Tepartment of Health and Mental Hygieney 1 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:52A Betty Lucille Nordaas SEPTEMBER22 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**X Days Hours Min 9-21-1950 Washington, DC 214-58-4370 61 Yrs. Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 Yes 2 X No MD Howard Columbia Columbia 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral U.S.A. 9795 Owen Brown Road 21045 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 1 No. Black, White, etc. ò þ 1 Never Married 2 A Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🕱 No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Howard County College (1-4 or 5+) Elementary/Seconday (0-12) Director of Elections Government $\mathbf{B}_{\mathbf{e}}$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Zella Hungerford William Walter Adams, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9795 Owen Brown Road Columbia, MD 21045 Arnstein Nordaas (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 x Cremation 3 Removal from State Glen Burnie, MD Atlantic Crematory 9-26-2011 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service Licen 22. Name and Address of Facility Witzke Funeral Homes 21045 161283 5555 Twin Knolls Road Columbia, MD 23a. Part 1. Enter the di ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart f-illure. Lis only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death RESPIRATORY FAILURE Phytician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MALIGNANT MESOTHELIOMA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events but to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 XNo Month 9 Unknown p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pleural and Peritonea. 23e. Did tobacco use contribute to the cause of death? Completed by Peritoneal RIGHT HEART FAILURE, Adhesions 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? LACTIC ACIDOSIS, Pericardial Adhesions 24a. Was an has autonsy page perform Yes ZKI No 1 X Yes 2 No STATUS POST LEFT PNEUMONECTOMY 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🛣No Hospital Other: ၉ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours at er death.

To the Funeral Drector Affe completed filled in by the fune. 1 X Natural 5 Pending iniury 1 Tyes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number D31826 9-22-4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD LINTHICUM M.D., 7601 OSLER DRIVE TOWSON, MD 21204 Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

SEP 3 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 31264 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 22, 11:40PM NAOMI ANTOINETTE NOVAK Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Glen Burnie Anne Arundel Funeral Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🗷 F Months Days Hours Min 36 9043 Director 71 MD Usual Residence of Decedent shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel 1 Yes 2 No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Catherine Avenue 21122 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2.X No Specify: 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Home Maker Own Home Be 2 should be filed Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked otf any injury or other traumatic eventone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vincent Allen Cunningham Clementine Fertitta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Novak - Husband 7821 Catherine Ave. Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 9/27/2011 Cedar Hill Cem Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses GJ Gonce Funeral Home 169 Riviera Drive 21122 Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onse and Death Immediate Cause (Final Physician neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immunist cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Compared at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 3 Probably 4 🗂 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performed Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Certificate: To 2 **N**o 1 PInpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Sentember completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. T Decedent's Name (First, Middle, Last) 3 2. Date of Death 3. Time of Death Physician/ September^D 2011 Dorothy C. Oles 8:13 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore S Towson St. Joseph Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 M 2 XF Days 213–16–4751 May 13, °1°920 Balt. 102/52/501 **Director** 91 Maryland Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Towson or 28a-f 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country United States 21286 items 23a Funeral 409 Virginia Avenue America 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ŏ à 1 Never Married 2 Married 1 Yes 2 No Specify. "natural" Completed 3XXWidowed 4 ☐ Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any Injury or other traumatic event, the Me Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Haupt unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10514 Longbranch Road Cockeysville, Maryland 21030 Mr. Anthony J. Oles, Jr./son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October St. Stanislaus Cem. 1 🟝 Burial 2 🗌 Cremation 3 🗌 Removal from State Dundalk, Maryland 2011 4 Donation 5 Other (Specify) 21. Signature of Fareral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Subdieno disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) Month Dav Year Pregnant at time of death been signed by the a should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 ☐ Yes 2 🗙 No 2 🗔 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other; Certificate: To 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 7-91 2 No Investigation 09/29/201 55AM within 24 hours after deatl To the Funeral Director. 28f. Location (Street and Number of Rural Route Number, City or Town, State) 406 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined tomo Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated npleted Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature of person who completed cause of death Item 23a) (Type, Print) Date filed (Mc State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-06933 Afameuna Jamaine Onwuka State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Medical Examiner AFAMEFUNA JERMAINE ONWUKA 0140 hrs September 14, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's Laurel 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Linder 1 Year If Linder 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign MARYLAND Country) Months Davs Hours Director 218-23-4911 1X M 2 F SEPT. 20 1988 22 Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No or 28a-f show mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland southent of Health and Menal Hygiene.

sortnert of Health and Menal Hygiene.

ry or other traumatic event, the Medical Framinary must handled. PRINCE GEORGE'S RIVERDALE Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 20737 6806 ZOOK PLACE uneral 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 V Never Married 2 Married 2 X No Yes SpecifAFRICAN AMERICAN 3 Widowed If Yes, Give Year 1 Yes 2 No specify: 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Com PRIVATE CONSTRUCTION 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) PATRICIA MOSQUEDA JAMES ONWUKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6806 ZOOK PLACE RIVERDALE, MARYLAND 20737 JAMES ONWUKA/FATHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State GATE OF HEAVEN CEME. 10-1-2011 SILVER SPRING, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service License 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart I. En Approximate Interval **Physician** re. List only one cause on each line Between Onset and /Medical Death a. Gunshot Wounds (2) of Torso Immediate Chrise (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transi sician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Voar 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the the Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown pleted 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy After this certificate has page 2 performed Com ✔ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other No 1 Yes 28a. Date of Injury (Month, Dey,Yeer) FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject shot FOUND: Natural 5 Pending 1 Yes 2 V No within 24 hours after death. the Sep 14, 2011 0033 hrs Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 4612 Garrett Ave., Beltsville, MD (Specify) Residence To the Hospital To the Funeral 4 🗹 Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E. September 14, 2011 word 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD State Registrar

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			4a. Facility Name (if not institution Franklin Square Hospit			1	lb. City, Town, o Rosedale	r Location of I	Death	4c. County of D Baltimore (
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	v amy		10a, State 10b, County		10c. City,	, Town or Locati	on				10d. Inside City Limits		
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lund	28a-f show any d at once,	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?		
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thing of	ns 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?					n? (Specify Yes or No Querto Rican, etc.)	lo- 14. Race - A White, et	merican Indian, Black,		
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N S	b and 27 is		Anthony Oleszo	zuk/Husband	1	612	8 Margl	enn Av	e., Balti	more MD	21206		
. je	r tra		20a. Method of Disposition		20b.	Place of Disposi crematory or oth	tion (Name of ce		Date	20c. Location - Cit	y or Town, State		
OL S	othe L		1 Burial 2 Cremation	_	316	eland M	' '	le 1 (0/1/2011	Balti	more MD		
Baltimore,	Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoo injury or other traumatic event, the Medical Examiner must be notified at once,		4 Donation 5 Other Spe 21. Signature of Funeral Service L		F101		ame and Addres	s of Facility	-X/	28 W 17			
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	sician		23a. Part I. Enter the disease, or c failure. List only one cause o	omplications that caused	the death	. Do not enter th					Approximate Interval Between Onset and		
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9 X	tendii use	icia	past 12 months?	4 Pregnant at	time of de	ath -	er (Specify)		,		,		
B	the at	Physician/N	1 Yes 2 No 9 V Unkn	a Oliviowii									
P. 0.	signed by I be detach	by F	Part II. Other significant conditio	ns contributing to death	but not re	esulting in the u	nderlying cause	given in Part l			e to the cause of death? Probably 4 Unknown		
<u>6</u>	been sig										autopsy findings available		
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of Vital Records,	certificate ector, page	Be	25. Was case referred to medical examiner?	[Hospital: 1] Innation	Cal				heck only one)				
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isio	r death rector: by the	Cat	2 Accident Investi	gation 28e Place of Ini	urv - At ho	ome farm stree				(Street and Number of	Rural Route Number, City		
Division	hours after incral Dire y filled in t	Certification:	3 Suicide 6 Could	not be	ary rain	omo, ram, or oo	, 140(01), 011100	banang, oto.	or Town,		rtara rtodio rtambor, otty		
Division of Vital Records, P.O. Box 68760, Bonital or Attrading Physician: The law requires that the death certificate he executed	Funer ely fil		29a. Certifier Certifying Phy	rsician: To the best of my	knowled	ge, death occurr	ed at the time	ate and place	and due to the car	ise(s) and manner as	stated.		
4	the the	Medical	Crieck only	iner:On the basis of exam and manner stated.		-							
Ę	≯ £ 8	Me	29b. Signature and title of certifier	and mailler stated.			29c. Licen	se number		29d. Date signed (Month, Day, Year)		
			Yamel Ranthe	11 m)			O.C.	M.E.		September 27	, 2011		
	5		30. Name and address of person w	no completed cause of de	eath (Item	23a)				1			
			Pamela E. Southall, MD	Assistant Medic	cal Exa	miner 900	W. Baltimoi	e Street, E	Baltimore, MD 2	21223			
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signatu	ire							

DHMH 17 Rev 1/2001 OCME 2006

11-07065 Gregory Parker, III Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Y September 19, 2011 1818 hrs 'cal Examiner Gregory Parker III 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital N/A 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or if Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Director Country) MD 09/01/1994 1 X M 2 F 17 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 X Yes 2 No N/A items 23a or 28a-f shovust, be notified at once. MD Baltimore cattimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other the death of the permit injury or other transmingury. Directo 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code U.S.A. 21216 2930 Windsor Ave. 14. Race - American Indian, Black, Funeral 11. Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes 2 X No Specify: Black 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A student 11th Grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arkimia Smith Be Gregory Parker II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2930 Windsor Ave., Baltimore, MD 21216 Arkimia Smith(mother) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 09/27/11 |Baltimore, MD King Mem. Park 4 Donation 5 Other Specify: Forme and Home PA 21. Signature of Funeral Service Licensee 2140 N. Fulton Ave., Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Retween Onset and failure. List only one cause on each line. /Madica Death a. Stab Wound of Torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and 명 AMENDED UNPENDED attending physician or use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Physi 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Ś 1 Yes 2 No 3 Probably 4 Unknown Completed has been a 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) of Vital Be examiner? Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes After the 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Subject stabbed FOUND: 1 Natural 1 Yes 2 ✔ No Pending neral Director: Sep 19, 2011 1740 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be Found, 114 North Poppleton Street, Baltimore, MD within 24 hours at To the Funeral D completely filled determined (Specify) Local Street the Hospital 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 20, 2011 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 8:30 AM Majorie McLeod Pearl September 28, 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min (Month, Day, Ye May 30, Year Country) **New Hampshir**e 83 1 🗆 M 2 🗙 F 557-46-2384 1928 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2211 West Rogers Avenue 21209 United States 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify. 3 Wldowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Donald Anthony McLeod Alberta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ron Pearl /Son 115 Brightside Avenue Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Sep 29 4 Donation 5 Other (Specify) Chesapeake Crematory 2011 Beltsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final esilita disease or condition DASH resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1

Ph sician/ Medical Examiner

that the death certificate be executed

Physician: The law requires Records,

To the Hospital or Attending

Box 68760

P.O.

Division of Vital

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page 2 certificate has

After this the funeral

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24 hours

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Completed

Be

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Certificate:

Medical

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Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

or 28a-f show notified at

ō

er than "natural", or items 23a or the Medical Examiner must be

hours after death

within 72 I Hygiene.

should be filed with and Mental Hygien ?

permit. Page 1 and 2 should be Department of Health and Ments. Important: If item 27 is marked any injury or con-

other traumatic event,

Maryland 21215-0036

Baltimore,

Director

Funeral

by

Completed

Be

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Examine that initiated events resulting in death) Last Physician/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying

25. Was case referred to medical

5 Pending

determined

1 ☐ Yes 2 ☑No

27. Manner of Death

1 X Natural

Accident

Suicide

4 Homicide

24a. Was an

Vo	3 Probably	4 Unknown	
4b.	Were autopsy fin	dings available	

autopsy performed? Yes 2 No 26. Place of Death (Check only one)

24b.	Were autopsy findings available
	prior to completion of cause of
	death?
	1 Yes 2 No

Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 M Other (Specify) MANOLO 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Investigation 1 Yes 2 No 6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

29a. Certifier (Check Check Ch	n, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner state
only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death	h occurred at the time, date and place, and due to	the cause(s) and manner as stated.
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) WES MY

5701 N. Charles ST TONION MO

32. Registrar's

Registrar

11-07068 Paul Pandajis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 1 1 3 1 2 7 0 State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar		Certifica	ate of De	eath			Reg. No.	
	Physic ''cal Exam	ian/	1. Decedent's Name (First, Middle,L	_{ast)} Lcholas	Panda					Day Year per 19, 2011	3. Time of Death
			4a. Facility Name (if not institution, of 10 Manor Circle C4	give street and number)			ity, Town, or L ikoma Par		Death	4c. County of Montgome	
	Funeral Director		1500.00	Sex 7. Age (In 7. Age (In 7.	yrs. last birtl 2		Under 1 Year onths Days	If Under Hours	Min.		9. Birthplace (State or Foreign Country) CT
	w any		Usual Residence of Decedent 10a. State 10b. County		. City, Town		To Irom a	Danle			10d. Inside City Limits 1 X Yes 2 No
	Maryland 28a-f show d at once.	ţ	10e. Street and Number	gomery			Zakoma Zip Code	raik		10g. Citizen of Wha	
	n the Mar 3a or 28a otified at	Director	10 Manor Circle	#4C			20	912		United	States
	hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Marri	1 Yes 2 X		If Yes, s	pecify Cuban,	Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	White,	
	rs after ural", miner	ğ	Widowed 4 X Divorce Decedent's Education (Specify	ed If Yes, Give Year or Dates:	ed) 16a, [2 X No		ind of work done	Specify: 16b. Kind of Busi	White ness/Industry
		eted	Elementary/Secondary (0-12)	College (1-4 or 5+)		during most of					·
	15-0036 filed within 72 hours afte I Hygiene. od other than "natural", t, the Medical Examiner	Completed		1	I	Entrepr		^ 	N	Securi	ty
	F. 6 8 7.	Be Co	17. Father's Name (First, Middle, La Nicholas	•	ndajis	3			Name (First, Middle istine	, walder surfame, Phot	of
	timore, MD 21215-0036 t. Pages 1 and 2 should be filed within 7 trant: of Health and Mental Hygiene. rrant: If iten 27 is marked other than yor other traumstic event, the Medical	ToE	19a. Informant's Name/Relationship							umber, City or Town,	
	and 2 si ealth ar em 27		Irene Pantages /			of Disposition			#1A, New I		06511 lity or Town, State
	ages 1 and of H		1 Burial 2 Cremation			ory or other pl beake C		ry	10/04/201	l Beltsv	rille, MD
	Baltimore, MD 212 permit. Pages I and 2 should by Department of Health and Ment Important: If tiem 27 is markinglary or other traumatic even injury or other traumatic even		4 Donation 5 Other Spec 21. Signature of Funeral Service Lic	ary.	382			- 1		ion Servic	es
	Physician		23a. Part I. Enter the disease, or co	name.		i 933	Gist A	ve.,	Silver S	oring, MD	20910
	/Medical		failure. List only one cause on								Between Onset and Death
	Examine r		or condition resulting in death)	Due to (or as a conseque							
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):						
	N- =	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):						
i	760, cate be executed physician and the burial - transit	cal E	X UNPENDED	d	- TT 2	7 202	ma a02	0 10	2 11 am		
	760, Cate be execut physician and the burial - tra	Medical	IF FEMALE:	#3.per me.gg	20 10= f pregnancy	3-11 s	me,g92	0 10-	-3-11 SIII	23d. Date of d	elivery
	ox 687 sath certifica attending p		23b. Was decedent pregnant in the past 12 months?	1 Live birth Dregnant at time	2	=		Ectopic	pregnancy	Month	Day Year
	Box 68: death certif	Physician	1 Yes 2 No 9 Unkno		e of death	Other ((Specify)				
	P.O. Box 68 es that the death certif igned by the attending be detached for use as	y Pr	Part II. Other significant condition		t not resulting	g in the under	lying cause gi	ven in Par			ute to the cause of death? Probably 4 Unknown
	cords, Plaw requires that been sign 2 should be contact.	ted	Cirrhosis of 1	<u>iver</u>					24a. Wa		ere autopsy findings available
	COFC law re has be e 2 sho	Completed by	-						per	formed? de	or to completion of cause of ath?
	tal Re ian: The certificate ector, page	ပ္သြ	25. Was case referred to medical				26.Place	of Death (Check only one)	3 2 No 1	Yes 2 No
	Vita hysicia this cel	To Be	examiner? 1 ✔ Yes 2 No	Hospital: 1 Inpatient	2 ER/0	utpatient 3				Residence 6	
	ision of Vital Records, P.O. Box 68: Attending Physician: The law requires that the death certifi r death. rector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as!	l :i	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b.	Time of Injury	1	y at Work? es 2 ☐		e how injury occurred	
	r Atten er deatl irector:	Certification:	2 Accident Investig	gation	- At home, fa	arm, street, fac			c. 28f. Location		or Rurat Route Number, City
7	Divinital of ours after in Filled in	Certi	4 Homicide determi						or Town	, State)	
کے	Division of Vital Records, To the Hoppital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	Medical	29a. Certifier 1 Certifying Physical Concept Cone 2 Medical Examination Control Contro	sician: To the best of my knoner:On the basis of examina and manner stated.	owledge, dea ation and/or i	ath occurred a nvestigation, i	at the time, da in my opinion,	te and pla death occ	ce, and due to the ca curred at the time, da	iuse(s) and manner a te and place, and du	e to the cause(s)
	To with	Me	29b. Signature and title of certifier	/ CA A A		-	29c, License				(Month, Day, Year)
	/		Carde A	tellair	/lto== 00-1		O.C.N	л.E.		September :	20, 2011
			30. Name and address of person w Carol Allan, MD Assis	stant Medical Examin	er 900 \		ore Street,	Baltimo	re, MD 21223		
		tate	31. Date filed (Month, Day, Year) SEP 3 0 2011	32. Registrar's S	Signature	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Puig Juanita September 9:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Owings Mills 3306 Nancy Ellen Way 9. Birthplace (State or Foreign Country)
Spain Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 7, 1928 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2X F 217-50-1473 83 **Director** May Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No Owings Mills Baltimore Maryland 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21117 3306 Nancy Ellen Way USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 72 hours after Maryland 21215-0036 X□ Yes 2□ No Specify: Spanish and Mental Hygiene. If Yes, Give Hispanic 3X Widowed 4 □ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Pablo Alonso permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Maria Herrero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3306 Nancy Ellen Way Owings Mills, Maryland 21117 Carlos Puig, Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Baltimore, Maryland Metro Crematory Inc. 09/29/11 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Physician/ HEURONIA irall disease or condition 20, Medical resulting in death) Due to (r as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery ō Month Year Dav been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform After this certificate 2 No Yes 2 1 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ပ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direct 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signat 29d. Date signed (Month, Day, Year) 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21224 O'Brien, M.D., Ph.D. 5200 Eastern Avenue Richard J. Registrar

State Registrar

Box 68760

DHMH 17 Rev 7/2009

SHARMA MD, ZOZ MenoniA

park

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHINTU 31. Date filed (Month, Day, Year)

SEP 3 0 2011

Raymond Paul Perry, Sr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 1 1 3 1 2 7 3 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Ce	rtificate	of.	Death			R	eg. No.		
Physici	an/	Decedent's Name (First, Middl	le,Last)		-				2	. Date of Dea			3. Time of Death
∕ledical Exami	ner	Raymond	Paul Perry, Sr. Month Day Year September 24, 2011 1									1932 hrs	
		4a. Facility Name (if not institutio	· -			41	b. City, Town, or	Location	of Death		4c. County o		
		Baltimore Washington	Medical Cente	r		н	Glen Burnie)			Anne Art	ındel	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday	')	If Under 1 Yea			8. Date of Bir	rth (MM/DD/YYYY)	9. Birtl Foreign	
Director		214-38-7349	1 X X M 2 F	68		Yrs.	Months Day	s Hours	s Min.	12-24	-1942		untry) TN
		Usual Residence of Decedent											
' any		10a, State 10b. County		10c. City	, Town or Lo	ocatio							10d. Inside City Limits
nd show	5	MD Anne	Arundel				G1	en B	urnie	2		- 1	1 Yes 2 X No
Aaryland 28a-f show I at once.	Director	10e. Street and Number					10f. Zip Code			1	0g. Citizen of Wh	at Coun	try?
th the Maryland 23a or 28a-f sho notified at once.		1016 A 7th Str	eet				21	.060			United	Sta	tes
with ns 23	eral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.		Decedent of His						can Indian, Black,
death r iten	Fune	1 Never Married 2 X Ma	arried Armed Fo	orces? 2XX No		If Ye	s, specify Cubar	i, Mexican	n, Puerto R	ican, etc.)	White	, etc.	
uffer of the oper of	by F	3 Widowed 4 Div	orced If Yes, Give Yes		1		Yes 2 X No	specify:	:		Specify:		White
ours : afur		15. Decedent's Education (Spec		de completed)	16a. Dece	dent'	s Usual Occupat st of working life	ion (Give	kind of wo	rk done	16b. Kind of Bus	iness/Ir	ndustry
6 72 h	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)						u)	Injecti	on	Mold
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Hygirthe		17. Father's Name (First, Middle,	•						•	First, Middle, 1 1e1 Hea	Maiden Surname)		
21215-0036 and be filed within 7 Mental Hygienc. marked other than c event, the Medica	Be	Jerry Jackson			140: 14								7: 0.1.
D 2 Shoul Ind M	၉	19a. Informant's Name/Relations									mber, City or Towr nie, Mary		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once.		Helen Perry - 20a. Method of Disposition	wire	20h			ion (Name of cer		<u> </u>	Date	20c. Location -		
Ortice of His		1 X Burial 2 Cremation	3 Removal fr	om State	crematory o	rothe	er place)					-	
iment ment or of		4 Donation 5 Other Sp		Mea									Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical.		23. Signature of Funeral Service	Licensee						-				al Home at
		Marc El	whav	سا									MD 21075
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause		aused the death	i. Do not ent	er the	e mode or dying,	such as c	cardiac or r	espiratory arr	est, snock, or nea	π	Approximate Interval Between Onset and
Examiner	ı	Immediate Cause (Final disease or condition resulting in death)		in Into		on	·						Death
		or condition resulting in death)	Due to (or as a	consequence o	of):								
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	틭	cause. Enter Underlying Cause (Disease or injury that initiated	c				-						
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3760, ficate be g physici s the buri	Š	IF FEMALE: 23b, Was decedent pregnant in th		outcome of preg sirth		Eata	al death 3	Ectonia	c pregnanc	ev.	23d, Date of of Month		ay Year
Sox 687 death certific e attending I for use as th	Si Si	past 12 months?		ant at time of de			er (Specify)		o programm				-,
Box 68 e death certil the attending ed for use as	Physiciar	1 Yes 2 No 9 Unk	known 9 Unkno	own									
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P.C. res that signed be deta	d b									1 Yes	s 2 No 3	_ Proba	ably 4 🗹 Unknown
Records, The law require	Completed									24a. Was			opsy findings available ompletion of cause of
e law te has	틹										rmed? d	eath?	
tal Rectian: The certificate ector, page		25. Was case referred to medical					26.Place	of Death	(Check on		2	V 100	
of Vital ng Physician: After this certi	o Be	examiner? 1 ✓ Yes 2 No	Una-itali	npatient 2	ER/Outpat	ient	3 DOA	Other ₄	Nursing	Home 5	Residence 8	Other:	
of \ing Phy	-	27. Manner of Death	28a. Date	of Injury	28b. Time	of Inj	ury 28c. Inju	ry at Work	k? 2	8d. Describe	how injury occurre	ed .	
Sion (Attendin death. sctor: A sy the fu	cation:	1 Natural 5 Pend	ing fd 9	, Day, Yaar) -23-11	fd 10	: 00)am □□\	es 2 X	.] No	unknow	m		
Division tal or Attendin rs after death. al Director: A	Ea		stigation				, factory, office b	uilding, et	tc. 2	8f. Location (Street and Numbe	r or Rur	al Route Number, City
Div pital o	Certific		mined (Specify)	re	siden	ce			G		state) 1016 <i>A</i> urnie, Mo		h St.
			nysician: To the bes						ace, and di	ue to the caus	se(s) and manner	as state	
To the Ho within 24 } To the Fu completely	Medical	one) 2 Medicai Exam	miner: On the basis of	of examination a	and/or invest	igatio	on, in my opinion	, death oc	ccurred at t	he time, date	and place, and du	ue to the	e cause(s)
E 3 E 3	\$	29b. Signature and title of certifie		idico.			29c. Licens	e number			29d. Date signe	d (Mon	th, Day, Year)
		light.					O.C.I	M.E.			September	25, 20	011
	ŀ	30. Name and address of person	who completed caus	se of death (Item	n 23a)								
		Ling Li, MD Assista	nt Medical Exar	miner 900	W. Baltin	nore	Street, Balt	imore, i	MD 212	23			
St	ate	31. Date filed (Month, Day, Year)		egi trar's Signati	ure 🔏	1							
Regist	rar	SEP 3	U 2017	Brown.	A.	190	ald						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Peter Ross Sept. 2011 4:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours **Director** 548-42-2537 1 **X** M 2 □ F 78 Aug. 18, 1933 Illinois Usual Residence of Decedent at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 3531 Twin Branches Dr. 20906 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
f Yes, Give an "natural", or iter Medical Examiner Black, White, etc. ģ 1 Never Married 2XXMarried 1 ☐ Yes 2X No Specify Completed 3 Widowed 4 Divorced Specify: White Year or Dates. 1954-57 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) University / College (1-4 or 5+)
5+ Elementary/Secondary (0-12) English Professor Higher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Martin Ross Liebe permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Zapler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine B. Ross / Wife 3531 Twin Branches Dr., Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Chesapeake Crematory | 09/27/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Live 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ RESPRIATORY FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami MULTIPLE MYELOMA Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be

P.O. Box 68760 Division of Vital Records, or Attending Physician: Hospital

28a-f

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Nomas

Joseph,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

29b. Signature and title of certifier

29a, Certifier (Check

Maryland 21215-0036

altimore,

To the I within 2. State 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

20852

29d. Date signed (Month, Day, Year)

SEPT. 26, 2011

City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0047330

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

50 W. Edmonston Dr. #207, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

UNK UNK		1- For State	ate of Maryland	•	rtment of F		d Mental I		20	11 312/3
Physicia Medical Exami		1.Decedent's Name (First, Middle	Oliver 7	Rollin	S			2. Date of Dea Month August 22		3. Time of Death 0034 hrs
		4a. Facility Name (if not institution Johns Hopkins Hospita		r)		City, Town, or Baltimore	Location of Dea	th	4c. County of	Death //A
Funeral Director		216-11-5994	5. Sex 7. A	ge (In yrs. Ia	_	f Under 1 Yea Months Days			rth (MM/DD/YYYY) 1985	9. Birthplace (State or Foreign Country)
land -f show any once.	tor	Usual Residence of Decedent 10a. State 10b. County N	A		Town or Location					10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	al Director	10e. Street and Number 3340 Elmore 11. Marital Status	Ave.			Of. Zip Code			Og. Citizen of Wha	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Mar	1 Yes 2 If Yes, Give Year or Dates:	? X No	If Yes,	specify Cuban s 2 🔀 No	n, Mexican, Puert specify:		White,	Black
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours a ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natura or other fraumatic event, the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)		of working life. abled	DO NOT use re	tired)	16b. Kind of Busi	ness/Industry
21215- uld be filed Mental Hyg marked oth	8	17. Father's Name (First, Middle, L Dwens Rol	lins				Cynt	hia k	Maiden Surname)	
MD 2 1 2 should th and M a 27 is m	٩	19a. Informant's Name/Relationshi Linda Jones			19b. Mailing Ad				nber, City or Town, , MD 2/2	213
		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Special	cify:	ate Car	ace of Disposition ematory or other p	(Name of cen	netery.	Date	20c. Location - C	ity or Town, State MD North Ave.
Balt permit Depart Impor		21. Signature of Funeral Service Li			1001	\mathbf{p}_{i} \mathbf{p}_{i}	3 2120	2		
Physician /Medical Examiner		23a. Part I. Enter the disease, or confailure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	omplications that caused n each line. a. Multiple Gunsho Due to (or as a cons	ot Wound		ode of dying,	such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
oe execu	dical	UNPENDED	dAMENDED							
Ox 6876 eath certificate attending phy for use as the	₽t	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown		2 Fetal d	eath 3 (Specify)	Ectopic pregn	ancy	23d. Date of de Month	elivery Day Year
S, P.O. B uires that the d n signed by the	2	Part II. Other significant condition	ns contributing to death	but not resi	ulting in the under	lying cause gi	ven in Part I.			te to the cause of death? Probably 4 Unknown
Vital Records, ysician: The law requir his certificate has been s director, page 2 should	Completed							24a. Was a autop: perfor 1 Yes 2	sy prio med? dea	re autopsy findings available or to completion of cause of th? Yes 2 No
Vital hysician hysician this certi	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 E	R/Outpatient 3		of Death (Check Other Nursin		Residence 6	Other:
Sion of Attending Ph death. Extor: After if y the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	ation	ear) 2	8b. Time of Injury 2224 hrs	1	y at Work? es 2 ✓ No	Subject shot		
Division the Hospital or Attent hin 24 hours after death the Funeral Director: npletely filled in by the		Suicide 6 Could n 4 Homicide determi	ned (Specify) Loc	al Street	e, farm, street, fac			or Town, St 2500 East Cha	tate) ase Street, Baltin	
To the Howithin 24 Po the Function Completely	ed	2 Medical Examin	ician: To the best of my ner: On the basis of exar and manner stated.	nination and	or investigation, i	n my opinion,	e and place, and death occurred a	at the time, date a	e(s) and manner as and place, and due	to the cause(s)
		9b. Signature and title of certifier	, VD			29c. License O. C.M			29d. Date signed August 22, 20	(Month, Day, Year) 011
21	3	O. Name and address of person wh Ling Li, MD Assistant	o completed cause of de Medical Examiner		,	treet, Baltir	more, MD 21	223		
Sta Registra	_	11. Date filed (Wonth, Day, Year)	3. Registrar	EA .	barker	,				

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State of Maryland / Departme					

	1- For State Registrar		Certificate of	of Death			g. No.	
Physiciar Medical Examin	er JASON	Kirk	Russel	1 111		2. Date of Death Month September	Day Year r 27, 2011	3. Time of Death 1030 hrs
	4a. Facility Name (if not instit 136 Tenant Lane	ution, give street and number)		4b. City, Town, Port Depo	or Location of Dea sit	th	4c. County of Death Cecil	
Funeral Director	5. Social Security Number 169 - 32 - 0305	1 M 2 F	In yrs. last birthday)	If Under 1 Ye Months Da		in.	h(MM/DD/YYYY) 9. Bir Foreig 8, 1942 Co	
daryland 28a-f show any 1 at once.	Usual Residence of Deceden 10a. State 10b. Cour		Oc. City, Town or Loc		Depos	1+		10d. Inside City Limits 1 Yes 2 No
the Mary is or 28a-	10e. Street and Number	LANE		10f. Zip Code	1905	10	g, Citizen of What Cour USA	•
5-0036 led within 72 hours after death with the Maryland tygene. other than "natural", or items 23a or 28a-f sho	11. Marital Status 1 Never Married 2	1 Yes 2	No If	Yes, specify Cuba	an, Mexican, Puert	Specify Yes or No- to Rican, etc.)	White, etc.	can Indian, Black,
hours afte "natural", Examine:	6	Divorced If Yes, Give Year or Dates: specify only highest grade complete: College (1-4 or 5+)	eted) 16a. Decede		lo s <i>pecify:</i> ation (Give kind of fe. DO NOT use re		Specify: U	ndustry
5-0036 lled within 72 Hygiene. tother than the Medical	Elementary/Secondary (0-1	4	_	tee of	1 400.01	SS10 US ne (First, Middle, M	Private	Schools
121 Id be fil dental I	JASON K 19a. Informant's Name/Relation	irk Russell	II	on Address (St.	F. <+1	co. M	Keck.	sie
MD and 2 sho alth and m 27 is aumati	- I a a l	rth - Sister	55 20b. Place of Dispo	8 Mt.	Hope R	Rural Route Numb	per, City or Town, State	rsity PA
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N important: If item 27 is in jury or other traumatic		ion 3 Removal from State Specify:					West C/	
Baltimo permit. Pag Department Important: injury or of	21. Signature of Funeral Servi		22.	Name and Address	ss of Facility J Conklin	oseph N	BAITO M	JRF.H. 121224
Physician /Medical Examiner	23a. Part I. Enter the disease, failure. List only one can Immediate Cause (Final disease)	O				or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
£Xaiiiiiei	or condition resulting in death Sequentially list conditions,							
ed nsit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C						
760, cate be executed physician and the burial - transit		d	erice or).					
760, cate be executed physician and the burial - trans	UNPENDED IF FEMALE:	23c. If yes, outcome of	of pregnancy				23d. Date of delivery	
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F, P.O. Be ires that the de signed by the lbe detached f		ditions contributing to death bu	ut not resulting in the	underlying cause	given in Part I.		acco use contribute to t	
of Vital Records, og Physician: The law requires ther this certificate has been signered director, page 2 should be						24a. Was ar autopsy	24b. Were aut	opsy findings available ompletion of cause of
Vital Rec ysician: The la his certificate h director, page 2						perform 1 Yes 2		2 No
Vital ysician his cert directo	examiner?	Hospital: 1 Inpatient	2 ER/Outpatien		e of Death (Check Other Mursin		esidence 6 🗸 Other:	Scene
ਵਜ਼ੀ ੂੈ ਵੀ ਹੈ	27 Manner of Death	28a. Date of Injury (Month: Day, Year) FOUND: Sep 27, 2011	28b. Time of FOUND: 1030 hrs		ury at Work? Yes 2 ✔ No	28d. Describe ho Subject shot	w injury occurred and cut self	
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	2 Accident Inv 3 Suicide 6 Cc 4 Homicide	uld not be 28e. Place of Injury	- At home, farm, stree Family Home	et, factory, office	building, etc.	or Town, Sta	reet and Number or Rur lite) ne , Port Deposit, MD	
Division Division To the Hospital or Attenwithin 24 hours after death whigh 12 hours after death completely filled in by the edical Certificati		Physician: To the best of my kn	nowledge, death occu					
To with To con	29b Signature and title of certification	and manner stated.	3950	29c. Licens O.C.	se number		29d. Date signed <i>(Mon</i> September 28, 20	
0	30. Name and address of person Victor Weedn MD JE	on who completed cause of death Assistant Medical Ex	,	V. Baltimore S	Street, Baltimo	ore, MD 21223		
State Registra	s SEP 302			7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ September 28, 2011 Alfred Herman Schober 5:30 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3525 Stansbury Mill Road Phoenix Baltimore County Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **¥**M 2 □ F Days Months Hours Aug. 09, 1929 82 213-26-9097 Yrs Baltimore, MD. Director Usual Residence of Decedent 28a-f show 10a. State 10b. Count with the Maryland aţ 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Baltimore County Phoenix 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code must be n 10g, Citizen of What Country Funeral 3525 Stansbury Mill Road 21131 United States hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. "natural", or iter Was Decedent Ever in U.S.

Armed Forces?

Army

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Year or Dates Korcean Conf. Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 ■Widowed 4 □ Divorced White Completed Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) the Civil Engineer Baltimore County Govt. other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental F 27 is marked of traumatic even t. Page 1 and 2 should be file treent of Health and Mental rtant: If item 27 is marked or jury or other traumatic ever ဂ္ Samuel Schober Thresa Bieler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Douglas A. Schober (Son) 12016 S. Meridian Line Rd. Cloverdale, IN. 46120 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State Department c Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Oct. 01, 2011 Greenmount Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. O. P. Name and Address of Facility. Program and Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 23a. Put I Inter the disease, proomplications that caused snock, or heart fallure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final MYOCARDIAL INFARCTION Onset and Dear Physician/ HINUTES disease or condition Medical resulting in death) Examiner ELLIPIDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to or as a consequence of and I-transit resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 2 🗌 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate l Yes 2 N 1 Yes 25. Was case referred to Be 26. Place of Death (Check only one) Hospital 2 No Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Director: After this 27. Man r of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 140, 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) TEXAS STATION CT. #210 TIMONIUM, MD 21093 RIC

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day :39 elstember 12011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bal timove lizabeth enter MSING If Under 1 Year If Under 24 Hrs. Security Numbe (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year, 1920 1 ▼ M 2 □ F Days Hours Director Oct. Maryland 219-01-2003 90 Usual Residence of Decedent 28a-f show 10b. County 10c City Town or Location hours after death with the Maryland must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21228 USA 108 S. Prospect Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 🔀 Yes 2 🗌 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Engineering Baltimore, Maryland 21 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Glanville Harry Spittel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 108 S. Prospect Avenue; Catonsviille, MD 21228 Margaret A. Harris Niece 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other pla Garrison Forest VA Cem 10/3/2011 Owings Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Fuller I Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death 'h sician/ disease or condition resulting in death) Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed burial-trar Due to (or as a consequence o ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical d P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death Yes 2 No Unknown 9 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Was an autopsy performed?
Yes 2 M, No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Division of Vital Reco After this certificate 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other မ 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending work? 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 320 Avenue 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 16.25 M BRENDA ANN JOHNSON SAUNDERS 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Montgomery Washington Adventist Hospital Takoma Park 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or Foreign **Funeral** Country) 1 🗆 M 2 🗓 XF Director 577-74-0721 56 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Funeral Director 1 X Yes 2 No Prince George's Brentwood MD10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? ŬSA 20722 3803 Windom Road Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Nutritionist other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Eunice Rose Pearson permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic David Johnson 20710 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5211 Newton St., Apt. T3, Bladensburg, Milford R. Best, II/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Suitland, Maryland 09-24-2011 Lincoln Mem. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 20746 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH,4111 PA Ave., Suitland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ISCHEL Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed COLON CANC attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 XNo Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 은 1 Impatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work 1 Yes 2 No ☐ Accident ☐ Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0063703 wath Um, MD 09120111 7000 CARROLL AVE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

SABYASACHI WAR

31. Date filed (Month, Day, Year)

SFP 3 0 2011

32. Registrar's Signature

TAKOMA PARK, MD

B VELLANKI,

3 0 2011

31. Date filed (Month, Day, Year)

8850, Columbia

32. Registrar's Signature

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MD-21043

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G919, 9/30/2011, WS
State of Maryland / Department of Health and Mental Hygien OH |

AMEND ITEM#17perFH, G920, 10/18/2011, WS
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 11:25 AM SEPTEMBER 28 LOUISE TURKS 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOSPITAL RANDAUSTOUN NORTHWEST Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) Hours Min Months Days 1 ☐ M 2 ☐ 212-24-8192 Balt more Director Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midical Evan, her mat be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ NO Funeral Director MD Nindsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Northmont 21244 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Yes 2 ☐ 6
If Yes, Give
Year or Dates: 1 ☐ Neyer Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: Completed by 3 ₩idowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ublic School 12 17. Father's Name (First, Middle, Last) **Harry Grooms** 18. Mother's Name (First, Middle, Maiden Surname, Be Helen P :00:111 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To In, State, Zip Code) Bullo ma 33 Northmonted /daughter 32 AnITA Hunter Baltimore, 20b. Place of Disposition (Name of Arbutus Crematory Science) 20a. Method Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arbuitus MD 4,2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ringly A. GRAYSON Fune ray Savice
370. Frad Hillar Pass Back, ma 21244 21. Signature of Funeral Service Licensee malda nungen 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KALEMIA **Physician** PER /Medical Due to (or as a contequence of): Examiner INSUFFICI RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-transit Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ₩No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1/Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director; 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OVD 2011 D54352 SEPTEMBER 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRCEA TOSOR NORTHWEST 40SPITAL SEP 3 U 2011 32. Registrar's Signature State arks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Year 12:45 PM September Rose Marie A. Thomas 29 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Towson Baltimore Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Min. Months Days Hours Director 86 216-58-2923 1 M 2 X F May 24, 1925 Germany Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No MD Baltimore Rosedale ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9527 Devonwood St 21237 United States be filed within 72 hours after death or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" Completed 3 ₩idowed 4 ☐ Divorced 27 is marked other than "natural" White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Own Home <u> Home Maker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည other traumatic Hermann Gebhardt Anneliese Hollander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is Christopher Thomas /Son Hill Drive Washington Crossing, PA 18 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State cemetery, crematory or other place, Oct 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 Signature of Funeral Service Licensee M01443 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury inding physician and use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy 5 Other (specify) ___ Live Birth 2 ___ red. ___ Pregnant at time of death in the past 12 months? Month Year Day signed by the a ld be detached f 9 Unknown Unknown P.O. Part II. Other significant condition contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Division of Vital Records, plnous Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autonsy death? certificate 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural Accider 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Lirector A

completely filled in by this Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title ature a 29d. Date signed (Month, Day, Year) 18211000 person who completed cause of death (Item 23a) (Type, Print) 6 av

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien & U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 3:35AM 2011 Medical Facility Name (if not institution, give street and number) 4b. City, Town Examiner Location of Death County of Death If Under 24 Hrs. 8. Date of Birth (Month, Day, If Unde 9. Birthplace (State or Foreign Funeral Age (In vrs. last birthday) Months Days Min Director 47 217-70-9587 1 X M 2 🗆 F BALTIMORE, MD JAN 19 1964 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No BALTIMORE MD 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21225 USA 951 EAST JEFFREY STREET items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, med Forc Black, White, etc. 1 Never Married 2 Married ō þ 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: Specify: BLACK "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **GOVERNMENT** INSPECTOR and Mental Hygie is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည GERTRUDE H. MILES ARTHUR WILLIAM THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).
951 JEFFREY STREET BALTIMORE, MARYLAND 21225
EAST 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st
Department of Health ar
Important: If item 27 is any injury or any CORNELLA THOMAS/WIFE Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 10/3/2011 RIVERDALE, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Ente shock, of h se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each ling. Immediate Cause (Final disease or condition Onset and Death Ph sician Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a sundequence of, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events and burial-tra Due to (or as a consequence of): resulting in death) Last physician s the buria Physician/Medical The law requires that the death certificate be Box 68760 as nding IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months? Month Day Year Pregnant at time of death
Unknown signed by the at be detached for Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Yes or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) inditions Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No Accident Investigation 6 Could not be nours after deat neral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of c 29d. Date signed (Mo 201 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ins. Fraure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death S Month 3. Time of Death 20:54M enni 201 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Haspita altimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F Month: Days Hours Min. Month Day Country) Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimor 1 X Yes 2 No 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Bace - American Indian 1. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: 3 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Contractor onstruction 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Savannah Dent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Balto 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) lennile, 21. Signature of Funeral Service License 1101 E. North March 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or Consequence of):

Aspiration Pneumonia 04 Secure tiniby list revealltions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ☐ Live Birth 2 ☐ Fetal Goal ☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending

Box 687 P.O. Records,

Division of Vital

attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed signed by the a should has page 2 certificate director, this

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Medical

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Maryland 21215-0036

Baltimore,

traumatic event, the Medical Examiner must be notified at

1 🗌 Yes မ After thi funeral 1 Natural Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Se 60716

State Registrar

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32. Registrar's Signature SEP 3 0 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 Thomas Lee Vanek 2011 3:02 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park 6. Sex 1 **X** M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday) Funeral OHIO Months Hours Min (Month, Day, 04 12 Director unknown Usual Residence of Decedent 10a. State 10b County within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Saint Marys Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27106 Dogwood Lane 20659 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Yes 2 No Yes, Give Completed by 1 ☐ Yes 2X No Specify. WHITE Specify: 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natur ury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Vanek Patricia Danford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Smith - SISTER 27106 Dogwood Lane, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Page 1
Department of I
Important: If it
any injury or or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4 Donation Metro Crematory INC 09-29-2011 Baltimore, Maryland neral Service Ligenses 21. Signature of Fi 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore, MD 21228 emin 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autonsv To the Hospital or Attending Physician: The la within 24 hours after death.
To the Funeral Director: After this certificate he completed filled in by the funeral director, page. 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1- Natural 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar DHMH 17 Rev 7/2009

State

only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

ANNA LACHTCHIN

29d. Date signed (Month, Day, Year) 128/2011

Maryland 20912

7600 Carroll Avenue,

amend #F Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 31286 1. Decedent's Name (First, Middle, Last) Charles Richard Williams III 2. Date of Death 3. Time of Death Physician/ Month Day 5:16 AM 2011 Medical na **Examiner** 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Baltimore Randallstown Genesis Nursing Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) Director 727-01-5557 84 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c City Town or Location notified at 10d. Inside City Limits Director MD NΑ Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be r Funeral U.S.A. 21216 2560 Arunah Ave 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1. Yes 2 No If Yes, Give Year or Dates. within 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service 12th grade <u>Accounting</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o permit. Page 1 and 2 should be .
Department of Health and Mental Important: If item 27 is many injury or other 0 Dorothy Robinson Charles R. Williams Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella G. Williams-Wife 2560 Arunah Ave, Baltimore, Md 21216 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Garrison Forest 10/3/2011 Dwings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 300 Wabash Ave, 21215 Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between failure Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Chrone c 0)~ Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Congestive heart failure that the death certificate be executed attending physician and for use as the burial-transit 12000 Due to (or as a consequence of) resulting in death) Last Physician/Medical Anemie of Chronic Disease Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery ~/ A 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown g Unknown NK Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 NO certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred <u>ن</u> the Hospital or Attending work? 1 Yes 2 No 10 Natural injury 5 Pending Certifica MA Accident Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) MO# D0072109 26/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallistour 9109 Randallitoin Centa liberty Roa MO 31. Date filed (Month, Day, Year) _ -State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G920, 10/6/2011, WS
State of Maryland / Department of Health and Mental Hygien 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O Physician/ 10/10 am Rene Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 2273-26-8329 7. Age (In yrs. last birthday) **Funeral** 1 **X**M 2 □ F Days Min. Months **Director** 212-36-8329 MD 80 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NA Baltimore 1 Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be i U.S.A. Funeral 2509 Halcyon Ave 21214 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 XMarried Maryland 21215-0036 Black 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Bethlehem Steel Corp. Welder 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic even Martha Watson Fate Owen Matthews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Halcyon Ave, Baltimore, Md 21214 19a. Informant's Name/Relationship (Type, Print) Gracie Watson-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10/3/2011 Forest Owings Mills, Garrison Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21215 Baltimore, Md 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between ediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Examine than y, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Hospital or Attending Physician: The law requires that the death Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops\ performed 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSDICE 2 00 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate; 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 17 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier HOD6476 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), HX Bolt 40 21201 JINJ Brace Linden Date filed (Month, Day, Year) State SEP 3 0 2011 Registrar

gewe watson

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

SEP 3 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) 31289 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month \mathbf{P}^{M} 2011 7:10 Ellen Rita Wilson September Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Brighton Gardens North Bethesda Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 🕱 F Hours October 24, Director 579-20-7077 Washington, 87 1923 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Marvland Montgomery Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6704 Buttermere Lane 20817 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ь þ 1 Never Married 2 X Married 1 Yes If Yes, Give Maryland 21215-0036 er than "natural", c 1 Yes 2 X No Specify 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+ Accountant Architecture/Design Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file, and Mental H ည Thomas Tuohy Catherine Cecilia O'Leary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar. Important: If item 27 is any injury or and Kenneth Wilson/Husband 6704 Buttermere Lane, Bethesda, Maryland 20817-1528 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 \square Cremation 3 \square Removal from State 8. November 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 2011 Arlington, Virginia 21. Signatur of Funeral Service Lice Robert A. Fumphrey Funeral Home, Bethesda-Chevy Chase, Inc. Chai Haran) M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced Dementia disease or condition Medical resulting in death) Examiner Due to (or as a consequence of Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events -tran and Due to (or as a consequence of) resulting in death) Last burial attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death bed 1 the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 ☐ Yes 2 🕱 No 1 Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No မ ER/Outpatient 3 DCA 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 I this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No the Accident Investigation Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) within To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0057458 September 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 M.D. Wisconsin Avenue #305, Bethesda, Maryland 20814 Pinky Singh, 32. Registrar Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18a Perf Man (2010) 10/04/2011 of Health and Mental Hygiene

			For State Registrar	State of Iviary		ertificate of L		and Montainy	Reg. No.	
ı	Physicia	n/	1. Decedent's Name (First, Middle, Last	t)		-		2. Date of De	eath Dan I Year	3. Time of Part D
	Medic	al	Janet Eldridge We			1			ber 20 101	
and.	Examin	er	4a. Facility Name (if not institution, give : Wilson Health Car			4b. City, Town, or	ither:		4c. County of De	
	Funeral		Social Security Number 6. Se	x 7. Age (In	yrs. last birthday)		If Under Hours	24 Hrs. 8. Date of Bir	th 9 B	Firthplace (State or Foreign
	Director		213-50-1016 Usual Residence of Decedent	_M 2 🖾 F 9 2	Yrs.	World's Days	riours	Min. (Month, De February	7 23, 1917 Was	shington, D.C.
	and show	٥	10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
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	h the	Funeral Director	10e. Street and Number	4		10f. Zip Code			10g. Citizen of What 0	Country?
	ath wil	nner	301 Russell Avenue	12. Was Decedent Ever	in II S 13		877	ain? (Specify Yes or No-	United 14. Race - Am	
9	er der or ite miner	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No	110.0.			gin? (Specify Yes or No- n, Puerto Rican, etc.)	Black, Wh	
003	ursaff tural", al Exa	ted	3 🛭 Widowed 4 🗌 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:		Specify: W	nite
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212	within giene. er tha the N		Elementary/Seconday (0-12)	College (1-4 or 5+)		Homemaker			Own H	ome
pu	filed half	o Be	17. Father's Name (First, Middle, Last)				18. Moth	er's Name <i>Eirst, Middle,</i> Tredwa dred Treadw	Maiden Surname)	
Zla	uld be J Ment marke natic	2	Arthur William El							
⊠	2 sho Ith and 27 is r traur		19a. Informant's Name/Relationship (Ty) Sandi Atkinson / D					er or Rural Route Numbe Vrive, Derwo		
ē,	1 and of Hea item other		20a. Method of Disposition	2	Ob. Place of Disc	osition (Name of		September 30,	20c. Location - City of	
<u>=</u>	Page ment c ant: If ury or		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Montgome Cremator	ematory or other place ry ium, Inc.	(e) S	eptember 30, 2011	Bethesda,	Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign ture of F) nefal ervi e Li	M01619			e of Facilit Pumph ntgomen	rey Funeral	Home, Roc ckville, Mary	kville, Inc. yland 20850
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the ne cause on each line.				*		Approximate Interval Between
~	Physician/		Immediate Cause (Final disease or condition	a Cardiac		ia				Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co		E-11				
	the fire	ner	Sequentially list conditions, cause. Enter Underlying	b. Conjesti		rallure				
	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	C						
	e exec cian ar urial-t		resulting in death) Last	Due to (or as a co	nsequence of):					
200	physic the b	Medical		d						
Division of Vital Records, P.O. Box 68760	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	regnancy				23d. Date of c	delivery
Box	death ne atte ed for	Physician/N	in the past 12 months? 1 ☐ Yes 2 🛣 No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		☐ Ectopic pregnand ☐ Other (specify)	У		Month	Day Year
o.	at the	Phy	g ∐ Unknown Part II. Other significant conditions co		ot resulting in the	underlying cause di	en in Part	l 220 Did t	obacco use contribute	to the cause of death?
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ord	requi	lete						24a. Was		autopsy findings available
ŞeÇ	Physician: The law this certificate has al director, page 2 a	Completed							ormed? death?	o completion of cause of ? /es 2 \(\sum \text{No}\)
<u>e</u>	ilan: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?	reacter va		26. PI	ace of Dea	th (Check only one)	ZIXINOI ILI	es z 🗆 No
\equiv	Physic this ce al dire	မ	1 ☐ Yes 2 🔀 No 27. Manner of Death		2 ER/Outpatie	. 1	4 L X L Nu	ursing Home 5 Resi		ecify)
n 0	ttending Phydeath. stor After thi	cate	1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Ye.	ar) 28b. Time (injury	work			how injury occurred	
Sio	lor Attern fter deat Director	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury -			100 2	28f. Location (Street and Number or F	Rural Route Number,
<u>≥</u>	itallor A irs fter al birec led in by			building, etc. (Sp		_		City or Tou	vn, State)	
	the Hospitallor Attending Physician: The law requires that the death certificate be executed hin 24 hours. Iter death. the Funeral Urrector After this certificate has been signed by the attending physician and impleted filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Medical	(Check 2 Medical Examir		ination and/or inve	stigation, in my opinio	on, death oc	courred at the time, date	and place, and due to the	e cause(s) and manner stated.
	To the I within 2 To the I comple:	Σ	only one) 3 L Certifying Nurs 29b. Signature and title of certifier	Practioner: To the best	of my knowledge	, death occurred at the 29c. License		and place, and due to the	ne cause(s) and manner a 29d, Date signed (Mor	
			1 72	/ I	ハロ	D6243	35		September	29, 2011
			30. Name and address of person who co				201			
	Check		Sayad Elsayyad, M.				206,	Rockville,	Maryland 2	.0850
	Stat Registra	e ar	SEP 3 0 2011	32. Registrar's	. gav					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ WARD Medical 4a. Facility Name (if not institution, give street and number) County of Death Examiner 4b. City, Town, or Location of Death Seasons Hospice & Palliative Care Randallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min 9/12/1945 176-38-3494 California **Director** 66 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location Director Maryland Baltimore 1 ☐ Yes 2 X No Owings Mills 10e. Street and Number 10f. Zip Code Ь 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 9401 White Cedar Drive #T15 21117 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other # Artist Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gustave Edward Zerne Winifred Steimling injury or other traumatic t and 2 should but Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Anne Canfield 9401 White Cedar Drive #T15, Owings Mills MD 21117 (Wife) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation 9/29/2011 Hanover, MD of Funeral Service License 22. Name and Address of Facility Latimore Funeral Services, P.A. 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ QREBRAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and tran Due to (or as a consequence of): burial physician s the burial Physician/Medical Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day ed by the a g Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? certificate Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 4 hours after death. uneral Director: After this ed filled in by the funeral di 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier n who completed cause of death (Item 23a) (Type, Print) 34 6 State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Physician/ 30 A M Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** OWSON AltiMobil 1ANOBLABE - TOWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Security Number Funeral (Month, Day, Year) Month Hours Min 212-34-4412 **Director** 1 □ M 2 💢 F 84 Apr. 17, 1927 Greece Usual Residence of Decede 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 🛣 No MD Baltimore Glen Arm 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 26 Manor Springs Court 21057 Greece Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married ☐ Yes 2

X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify "natural", 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 2 Michael Skarlatou Eugenia Tsoumbos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 s of Health Dimitrios Apostolou - Son 26 Manor Springs Court, Glen Arm, MD 21057 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or c 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Q Other (Specify) 5 Other (Specify) Demetrios Cemetery 9-17-2011 Parkville, MD 21. Signat 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ENd SLAGE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions ir any, leading to immediate cause. Enter Underlying Due to (or as a consequence or Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last physician ar Due to (or as a consequence of): Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Dav Pregnant at time of death the P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : performe 1 Yes 2 No Yes 2 No Division of Vital rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 I Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred Director: After d in by the funer Natural 5 Pending work? Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Effectifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature e and address of person who completed cause of death (Item 23a) (Type, Print) 8813 WAILHAM Woods Rd \$204 PARKVILLE 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Sept. 1^Pf^y, 201[°]f^r William Alfonte, Jr. 10:59 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Solomons Calvert Solomons Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min Month, Day, March25 Georgia 1 XM 2 🗆 552-40-1720 Director 87 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Calvert Solomons 1 Yes 2XXNo 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 635 Runabout Loop USA 20688 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1951-1 Never Married 2XX Married ۾ 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced White 1970 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Military Nuclear Engineer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William A. Alfonte, Sr. Josephine Anslyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD20688 635 Runabout Loop, Solomons, Mary A. Alfonte - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 D Other (Specify) Clinton, MD Sept 14,2011 Lee Crematory Signature of Funeral Service Licensee manda M. 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Ergler M.E 20736 la 8200 Jennifer Lane, Owings, MD 23a Part 1. Enter the disease. Part 1. Enter the disease, complifations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Accident Physician/ ere bro vascular disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (ur do a compequence of, Cause (Disease or iinjury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the leted filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pendina work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the only one) 29b. Signature and title of certifier 29c. License number Sept. 12, 2011 hanles W. D25156

KM

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Charles W. Bennett,

31. Date filed (Month, Day, Year)

11845 H.G. Trueman Road, Lusby, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mong 11:34 Shirley Mae Allen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Peninsula legional medical Salisbury **Funeral** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 👿 F (Month, Day, Mav 9. 213-42-0938 Days Hours Director 71 Yrs Marvland Usual Residence of Decedent 28a-f shov 10a. State 10b. County items 23a or 28a-f sho er must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Wicomico Salisbury 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21801 27466 Log Cabin Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 27 is marked other than "natural", or iter traumatic event, the Medical Examiner 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 XNo Specify. 3 □XWidowed 4 □ Divorced Black Completed Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th 9th Linen Of The Week Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gertrude Bishop Levin Truitt f and 2 should to f Health and Me ttem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Allen 27466 Log Cabin Road- Salisbury, Maryland 21801 permit. Page 1 and 2 Department of Healti Important: If item 2 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Springhill Memory Gdns 09/16/2011 4 Donation 5 Other (Specify) Hebron, MD Signatur of Funeral Service Licensee Salisbury, MD 22. Name and Address of Facility any Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ 58hic disease or condition resulting in death) Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or illipury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? After this certificate 1 🗌 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident after death Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 163199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHORE DR. SALISBURY, MD. 21804. YOGEVSH VOHA 910 EASTERN 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09-14-201 P Albright 7:30 PM Gladys Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton 6002 Lottie Pl. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Days 12-16-1924 186-20-0969 86 Yrs. **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Clinton 1 X Yes 2 No MD 10f. Zip Code 20735 10e. Street and Number 10g, Citizen of What Country? 6002 Lottie Pl. USA ı "natural", or item edical Examiner n 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify Black 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pittsburg Public Schools Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ada Bell Harris Mental John item 27 is marke other traumatic Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6002 Lottie Pl. Clinton, MD 20735 Charita Albright/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot once. 1X Burial 2 Cremation 3 Removal from State Cheltenham, MD MD Veterans Cemetery 9-21-2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH Signature of Funeral Service Licensee 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ cral Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part U. Othes significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy death? 1 🗌 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. work? 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature a 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 13635 State

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Registrar

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	Director		299–03–7063 Usual Residence of Decedent	1 X M 2 □ F	92	Yrs.	Months Days	Hours Min.	(Month, Day, March 1	^{Year)} 1919	Ohio	try)	4
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Mary	should h and N 7 is ma trauma		19a. Informant's Name/Relationsh				g Address (Street	and Number or Rura	l Route Number, verna Pa				
آ	and 2 s Health tem 27 other tra		Mary Bridger / 20a. Method of Disposition	wite	20b. Plac		ition (Name of	-		20c. Location			\dashv
altimore,	age 1 ent of nt: If i		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cem	netery, crem	atory or other place as Cemete		16	Crowns			
alti	permit. F Departm Importa any inju once,		21. Signature of Funeral Service Li		1.10 V					rna Da	rk Fin	neral Home	\exists
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			23 Fart 1. Enter the disease, or shock, or heart failure. List o	complications that caused only the cause on each line	the death. [e.	Do not ente	1111		00	0		Approximate Interval Between Onset and Death	
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	cate be executed physician and the burial-transit	_	resulting in deathy cast	bue to (or as	a consequen	106 01).							
Box 68760	ficate g phys as the	Medi		d									7
ŏ ×	h certi tendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth			Ectopic pregnance	Cy		1	ate of delive	,	-
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P.O.	that the	by Ph	Part II. Other significant condition	ons cont outing o death	ut pot resulti	ire in the ur	derlying cause gi	ven in Part I.	23e. Did tol	pacco use con	tribute to th	e cause of death?	
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Re	sician: The la certificate ha irector, page 2	Con							perform 1 Tyes	ned?	death?	2 D N	
Ta I	sician certifi irector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	- 57 -4		Oth	lace of Death (Check					\dashv
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Division of Vital	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the but	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi			e, farm, stre	et, factory, office		28f. Location (St City or Town		er or Rural	Route Number,	
	ospital hours uneral ed filled	Medical	29a. Certifier 1 Certifying	Physician: To the best of	my knowled	ge, death o	ocured at the time	e, date and place, an	d due to the caus	se(s) and man	ner as state	d.	1
į	the H thin 24 the Fu mplete	Me	only one) 3 Certifying	xaminer: On the basis of e Nurse Practioner: To the			eath occurred at th	e time, date and plac	e, and due to the	cause(s) and n	nanner as sta	ated.	30.
	5 ≥ 6 ⊗		29b. Signature and title of certifier	la hardo	tin	L	29c Licens	S/4	1 2	9d. Date signe	13	2011	
			30. Name and address of person y	who completed cause of d	eath (Item 23	Ba) (Type, Pr	int)	2015		OPI	<u></u>	11 00	-4
	Stat	_	31. Date filed (Month, Day, Year)	32. Redistra	ar's Signature	Y) Y .	VII), 6	XUD IC	agt	14 H	RI	through !!	1
	Registra		SEP 15	5 2011 Sens	un ,	8. A	arke						1

Registrar

SEP 1 5 2011

Registrar

31. Date filed (Month

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Delvin С. Brooks 10, Sept 10:50PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's **Examiner** Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🖳 M 2 🗆 F Davs Hours 0 c Month Pay, Year 958 Ountry) 52 218-80-9609 **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director MD Charles Waldorf 1 Yes 2XXNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? USA 23a 5060 Blenny Court 20603 Funeral Hygiene. other than "natural", or items and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Yes, Give **Black** 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Worker Construction and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shirley Sorrel1 ပ unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 5060 Blenny Court Waldorf, MD 20603 Illinois Brooks/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

John UMC Cem. 9/17/2011 X Burial 2 Cremation 3 Removal from State Lusby, 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sewell 1451 Dares Beach Rd. Funeral Home, P.A. Prince Fred., MD20678 21. Signature of Funeral Service Licensee Hadep 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each lide. Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Physician/Medical as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No JO. Year Month Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? Jas page 2 autopsy performed' this certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2: No Other: 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 \(\subseteq \text{Yes} \) 28b. Time of Certificate: 28d. Describe how injury occurred After 5 Pending injury Natural within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 No Investigation Accident 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examine/: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and e of certifier 3 KW Arastoo completed cause of death (Item 23a) (Type, Print)

State Registrar

16

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

32. Registrer

Amend #1 AACO Heal) . 9–15–11 KAH Please	Type or Pri							-		_	le.	
			For State Registrar	State of M	arylar			ent of F ete of D		nd Me	ental Hy	gien Reg. N	C 0 1	1 31	300
F	hysicia	n/	1. Decedent's Name (First, Middle, La	^	2./					- 1	2. Date of De Month	ath	ay Ye	ear .	of Death
	Medic Examin		4a. Facility Name (if not institution, give			0 1			Location of D	eath	septemb.	4	c. County of I	Death	51 PM
F	uneral	•		Sex U 7. Aq	i <mark>cal (</mark> e (In yrs. I	cntcr last birthday)	If Unc	ler 1 Year	Burn If Under 24	Hrs.	8. Date of Bir	th	Inne	Arunc Birthplace (Sta	e or Foreign
D	irector		303-52-5295 13 Usual Residence of Decedent	XM2□F	64	Yrs.	Months	s Days	Hours	viin.	(Month, Da March	22,	1947	Country) Indiana	à
Maryland	28a-f shov otified at	irector	10a. State 10b. County Anne Ar	undel		sy, Town or L Sever		rk							City Limits Yes 2 XNo
with the	23a or	eral D	10e. Street and Number 404 Sheffield R	oad			10f. Z	ip Code 21	146			10g. C	itizen of Wha	t Country?	
17+P 3036 Irs after death	Important: If item 27 is marked other than 'natural', or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 I If Yes, Give Year or Dates.V	No WW	II	If Yes, sp	ecify Cuba	ispanic Origin In, Mexican, P Specify:					American Indian White, etc. White	
Expert 21215-0036 within 72 hours after	an "nat	Completed	15. Decedent's Elementary/Seconday (0-12)	ade completed)		(Give		ual Occup- ork done o	ation during most of	working	,	16b.	Kind of Busin	ess Industry	
State of within	other than	Be Co	17. Father's Name (First, Middle, Last)	College (1-4 or 5)+)			chnic		News				Technolo	 DGA
Christian Robert Maryland 21215-0036 2 should be filed within 72 hours after thand Merial Hydrene.	atic eve	To	Charles Irvin C	onner							First, Middle, Geniev		arsons		
Mar Mar	27 is m r traum	19	19a. Informant's Name/Relationship (7	'					and Number of				r Town, State		
) nore,	or othe		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐	Removal from State	0	Place of Disp cemetery, cre	matory or	other plac	e) S		^{te} 19,		ocation - Cit	y or Town, State	
Baltimore,	Importan any injury once,		4 Donation 5 Other (Special 21 Synature of Fundal Service Ligen:		Me	tro Cr)11			•	Home
	프 늄 링		27. Part 1. Ent or the disease, or com	olications that caused	the deat	h. Do not en	195 R	itchi	e Hwy,	diac or r	Seve	erna rest.	Park,	Funeral MD 211	
	sician/	A	shock, or leart failure. List doly of Immediate ause (Final disease condition	ne cause on each line	t.				02 0					Interval I Onset ar	Between
	edical iminer	1	resulting in death)	Due to (or as a	,	uence of):	ONIA								
98	ısıt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or immy	Due to (or as a	consequ									50	
e execu	⊆ .@	_	that initiated events resulting in death) Last	Due to (or as a			,, ,,	<i>,,,,,,</i>						_	
68760 ertificate b	g physician as the burial	Medic		l d					-			_			
ath o	y the attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of a Live Birth 4 ☐ Pregnant at g ☐ Unknown	2 🗌 Feta	al death 3	☐ Ectopic ☐ Other (:		у			J	23d. Date o	f delivery Day	Year
5, P.O. es that the	gned se de	হ	Part II. Other significant conditions of	ontributing to death be	ut not res	ulting in the	underlying	j cause giv	en in Part I.					e to the cause o	
ords w requir	s been s	Completed									24a. Was	an	24b. Were	Probably 4	js available
Rec : The la											autor perfo 1 Yes	rmed?	deat	to completion of h? Yes 2 No	of cause of
Vita	0 0	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆	ER/Outpatie	ent 3 □ [Otho	er: 4 Nursir			dence	6 □ Other (S	pecify)	
on of oding Pt	Vfter th		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injur (Month, Day	y ; Year)	28b. Time o injury	of M	28c. Injury work	at at	28	d. Describe h				
Division of Vital Records, lal or Attending Physician: The law requires stater death.	d in by the f	Certificate:	3 Suicide 6 Could not b 4 Homicide determined		ry - At ho . <i>(Specify,</i>	me, farm, st				-	f. Location (S City or Tow			Rural Route Nu	mber,
Dj. To the Hospital o	Funeral eted filled	Medical	29a. Certifier 1 Certifying Physical Exami	sician: To the best of oner: On the basis of ex	my knowl	edge, death	occured a	at the time,	date and placen, death occur	e, and o	due to the car e time, date a	use(s) a	nd manner as	s stated. the cause(s) and	manner stated.
To the within	To the		only one) 3 L Certifying Nurs	se Practioner: To the b	oest of my	/ knowledge,	death occ	urred at the	time, date and number	d place,	and due to the	e causei 29d. Da	(s) and manne ate signed (M	r as stated. onth, Day, Year)	
		-	30. Name and address of person who	completed cause of de	eath (Item	23a) (Time	Print)	200	5370	3		Se	eptem	bor 13,	2011
CHE	4		BACI MONU 31. Date filed (Month, Day, Year)	completed cause of de 32. Rigistra	(6 D)	1 11	י זמט	AL	Cor	non	- G	10	r Bu	RNIE	MS
R	State legistra	_	SEP 1 5 20)11 Sener	rs Signat	B. 4	back	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per fh 991 11-4-11 vt State of Maryland 7 Department of Health and Mental Hygiene 0 | | 3 | 30 | State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Kathleen Cullinane Sept 14,2011 12:05a M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Fairland Nursing Home 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 214-82-6897 1 🗆 M 2 🗶 F Hours Wash DC Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Rockville 1 AYes 2 □ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country: United States Citizen of What Country? 20852 11813 Magruder Lane 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2X No Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give ₩idowed 4 X Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assitant Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ivan Radan Estela Edgar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ivan Radan/Father 11813 Magruder Lane, Rockville, MD 20852 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 9-16-2011 National Crematory Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) Joseph Gawler's Sons, INC Funeral Service Licerses 21. Signature 22. Name and Address of Facility 4 9 02 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Heter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Non Alcoholic Steatorrheaic Hepatitis With Cirrhosis disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-varies Division of Vital Records, P.O. Box 68760 ed by the detached signed b ieral Director; After this certificate has filled in by the funeral director, page 2 s after death within 24 hours a

Physician/

Funeral

Director

ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be

Physician/

Medical

Examine

Physician/Medical

Be Completed by

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Certificate:

Medical

29a, Certifier

29b. Signature and title of certifie

Examiner

Baltimore, Maryland 21215-0036

Medical **Examiner**

10a. State

MD

Director

Funeral

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Completed

Be

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			1		
IF FEMALE: 23b. Was decedent pregnant in the past 12 gonths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		23d. Date of delivery Month Day Year			
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?		
		1 ☐ Yes	2 ☐ No 3 ☐ Probably 4 🛱 Unknown		
		24a. Was an autopsy performed?			
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)			
1 Ves 2 XNo	Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4★ Nursing Ho	me 5 Residence	6 ☐ Other (Specify)		
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	on Sate of injury 236. Time of 28c. Injury at work? M I □ Yes 2 □ No	28d. Describe how inju	ury occurred		
4 Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)			

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D37142

29d. Date signed (Month, Day, Year) Sept 14,2011

Registrar

State

completed

To the

G. Coleman, M.D. 1355 Picard Dr, Rockville, MD

30. Name and address of person who completed cause of deth (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

-	Type of Triffe in Black machine mik. Ensure An Copies Are E.	Κ:
	State of Maryland / Department of Health and Mental Hygiene	J

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:00P M September 13, 2011 Mary Theresa Cullen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Rockville Montgomery Arbor Place If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 1 (Month, Pay, Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 140-16-4539 1 M 2 X F Jamonth, 22, Year 922 CNEW Jersey Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ms 23a or 28a-f s must be notified Rockville Maryland Montgomery 1 🗌 Yes 2 🍱 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20853 14721 Crossway Road items 2 Page 1 and 2 should be filed within 72 hours after death vment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Community Aide Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) ည Elizabeth Butler Patrick Hyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 14721 Crossway Road, Rockville, MD 20853 John P. Cullen / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 A Removal from State September Department of Important: If any injury or once. Holy Name Cemetery Jersey City, NJ 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Francis Address of Collyins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 2090 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 7 Opset and Death Physician/ Dementia, end Stage disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) the attending physician and hed for use as the burial transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 X No Month Year Pregnant at time of death Dav s been signed by the should be detached 1 ☐ Yes ∠ ☑ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Normal Pressure Hydrocephalus 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an page 2 s After this certificate has performed' Chronic Renal Insufficiency 1 ☐ Yes 2 🔯 No Yes 212 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Assisted Hospital 1 ☐ Yes 2 🔀 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of injury (Month, Day, Year) o the Hospital or Attending Phythin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 00 29d. Date signed (Month, Day, Year) September 14, 2011 29c. License number D0035045 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Philip G. Henjum, MD 18109 Prince Philip Drive #200, Olney, MD 20832 31. Date filed (Month, Day, Year) State faces 16 201 Registrar

CALLED

		For State		Stat	te of N	/larylan		-				/lental Hy	/gien	e- 0 1 1		1000
		Registrar 1. Decedent's Name	e (First, Middle	. Last)	_		(Certifica	te or L	Jeath		2. Date of D	Reg. N	lo.	3 -	Time of Death
Physicia		ARMANDO										SEPTEN		18 201		9:12 AM
Medic Examin		4a. Facility Name (if						4b. Cit	y, Town, or	Location	n of Death			c. County of Dea		
		54 SYCA						_	ORTH						CIL	
Funeral Director		5. Social Security No. 562–42–79		6. Sex 1 XX M 2		ge (In yrs. I	ast birtha Yr	Month	ler 1 Year s Days	Hours	er 24 Hrs. Min.	8. Date of Bi (Month, D APRIL	rth av Year) 8, 1	935 CAI	thplace (ountry) LTFOF	State or Foreign
d d	ı.	Usual Residence of 10a. State	Decedent 10b. County		•	10c Cit	y Town c	r Location							10d In	side City Limits
anylar la-fsl	Director	MARYLAND	CEC	тт		100.00		NORTH	ፔ ለርጥ							Yes 2 No
or 28	Dir	10e. Street and Nun		11					Zip Code				10g. C	Citizen of What C	1	ur.
s 23a	Funeral	54 SYCAM	ORE DR	.IVE					2190)1			UN	ITED STA	TES	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Marri 3 Widowed		ried Arme	ed Forces' Yes 2	Ever in U.S MARI 1951-	NES	If Yes, sp	ecify Cuba	n, Mexic	Origin? (Special, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit Specify: H		
in 72 hours e. nan "natur Medical	Completed	(Spe	cify only highe	nt's Education est grade comp			16a. D	ecedent's Us Give kind of w fe. DO NOT u	rork done d	ation during mo	ost of work	ing		Kind of Business PARTMENT	_	
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be filed ental H ked of ic ever	To B	17. Father's Name (i										e (First, Middle S CARBI		n Sumame)		
hould and Mi s mar		19a. Informant's Na					19b. N	Mailing Addre	ss (Street a					or Town, State, Z	p Code)	
und 2 s lealth a im 27 i		KATHERINE		NS / DA	AUGHT					CREE?	r, PE	RRYVILI		MARYLANI		1903
Page 1 a nent of H int: If ite		20a. Method of Disp 1 ☐ Burial 2x 4 ☐ Donatio	Cremation	3 Removal	Lfrom Stat	e c	cemetery,	isposition (No crematory of LE CRE	other plac		SEPT	EMBER 2011		Location - City o		
permit. Departn Importa any inju		21. Signature of For	dera Service	icensee				22. Name	and Addres	ss of Fac	ilityCRO	UCH FUN	IERA	L HOME, EAST, MAR	P.A.	
		23a. Part 1. Enter t shock, or hear	he disease, or rt failure. List d	complications only one cause	that cause on each li	ed the deat	th. Do not					-			Appi Inter	roximate val Between
Physician/ Medical		Immediate Cause (disease or condition resulting in death)		a. Du	le to (or as	s a consequ	uence of	facil	ш.	(CKI	١			Onse	et and Death
Examiner	Je.	Sequentially list co	nditions,	b. —	Pe	pu	uil	, Ver	su	rloi	n d	Seen	e,			
uted d ansit	Examiner	if any, leading to in cause. Enter Under Cause (Disease or that initiated events	rlying iinjury	6	Je to (or as	s alconsequ	uence of)									
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afferd death. To the Funeral Director: Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 4	Live Birth	at time of	al death	3 Ectopi 5 Other		ру				23d. Date of de Month	elivery Day	Year
hat the ed by t detach		Part II. Other signif		ons contributing	g to death	but not res	sulting in	the underlyin	g cause giv	ven in Pa	art I.	23e. Did	tobacco	use contribute t	o the cau	se of death?
quires t en sign vuld be	ted by											1 □	Yes :	2 □ No 3 🗹 F	robably	4 Unknown
The law reate has be bage 2 sho	Completed										_	per	s an opsy formed?	prior to death?	utopsy fir completi	ndings available ion of cause of
sician: The la certificate ha irector, page 2	Be (25. Was case referre examiner?	ed to medical	Hospital:							eath (C <i>h</i> ec					
Physic this c	۲.	1 Yes 2 2 27. Manner of Deatl			1 Inpa		ER/Outp	patient 3 🗆	DOA Othe	4 🗀				6 Other (Spe	cify)	
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al or Atte s after de al Directo ed in by th	I Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	ined 28e.		njury - At ho etc. (Specif)		, street, facto	ory, office			28f. Location City or To		and Number or Ru te)	ıral Route	e Number,
ie Hospit n 24 hour ie Funera bleted filk	Medical	(Check 2	Medical E	Examiner: On the	ne basis of	examinatio	n and/or i	nvestigation,	in my opinio	on, death	occurred a	t the time, date	and place	and manner as si ce, and due to the e(s) and manner a	cause(s)	and manner stated
To th withi To th	-	29b. Signature and	title of certifie	and	ele,)		2	9c. License			183	29d. D	Pate signed (Monitor)		
		30. Name and addr	ess of person	who completed	d cause of	death (Iten	n 23a) (Ty	pe, Print)		106	, 0	· U		1 61	<i>د</i> ر(<i>-</i> 11
CI		Dr. Madh	u Sach	dev, MD	32 Regiet	2 Eas	t Ce	cil Av	enue,	Nor	rth E	ast,Mar	y1aı	nd 2190	1	
Stat Registra		31. Date filed (Mont.	21 201	1 12 n	W L	trar's Signa	par	Kel								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 7:20 AM 2011 Kate G. Deitrich September Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Manor Healthcare Center Rising Sun Cecil . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, You 1 □ M 2 🗶 F Months Days Hours Year) Director 227-22-2597 Virginia Jan. 1919 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It ament of Health and Mental Hygiene. It and It if item 275 is marked other than "natural", or items 23a or 28a-f sho uny or orther traumatic event, the Medical Examiner must be notified at uny or orther traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1881 Telegraph Road 21911 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Factory <u>Seamstress</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Nuton Johnson Mary Smythers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claude A. Perry, Jr. 446 Roop Road, Rising Sun, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State $09-2^{\text{Tate}} = 2011$ 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) West Nottingham Cemetery Colora, Maryland 22. Name and Address of Facility RT Foard Funeral Home, P.A. 21. Signature of Funeral Service Licent 111 S. Queen St., Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE disease or condition Medical resulting in death) Examiner CARDIOM Securitally flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of Pospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physician and After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 N death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pendina 1 Yes 2 No Accident Investigation To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signatur

SUN

completed cause of death (Item 23a) (Type, Print)

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 Physician/ Year Elsie Docherty 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11 Sumpter Lane Cecil **Elkton** Social Security Number 8. Date of Birth (Month, Day, Year)

April 8, 1922 **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 - M 2 X F Hours Min. 206-12-1870 89 **Director** Rennslear, NY Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 10b. County 10a, State 10c. City, Town or Location Director MD Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 Sumpter Lane 21921 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Townsley William J. McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Montgomery Lane Elkton, MD Nellie C. Simpson (daughter) 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ■ Burial 2 □ Cremation 3 ■ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Sept. 19, 2011 Lawn Croft Cem. Linwood, PA 21. Signature of Funeral Service Licensee Mod 764 Name and Address of Facility
 McCrery & Harra Funeral Homes & Crematory, Inc. 3924 Concord Pike Wilmington, DE 19803 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SICK Sinus Physician/ nd-one disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Tachn condia Fram the attending physician and hed for use as the burial-tran Physician/Medical þ Be Completed မြ

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires i within 24 hours after death To the Funeral Director: After this certificate has been sign

Sequentially list conditions, b.	~		7-0-2
cause. Enter Underlying Cause (Disease or iinjury that initiated events Cause (Disease or iinjury that initiated events	40 years.		
resulting in death) Last Due to (or as a consequence of): d.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ector 4 ☐ Pregnant at time of death 5 ☐ Other			ate of delivery Ionth Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying the limes bement: a	ng cause given in Part I.		tribute to the cause of death?
Colitis		autopsy performed?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical	26. Place of Death (Check or	nlv one)	
examiner? 1	DOA Other: 4 \(\sum \) Nursing Home	e 5 🗶 Residence 6 🗌 Oth	ner (Specify)
27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	28c. Injury at work? 1 🗆 Yes 2 🗆 No	d. Describe how injury occur	red
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, fac building, etc. (Specify)	tory, office 28	of. Location (Street and Numb City or Town, State)	ber or Rural Route Number,
29a. Certifier (Check conly one) 3 Certifying Physician: To the best of my knowledge, death occured to the best of my knowledge, death occured to the best of my knowledge, death occured to the best of my knowledge, death occured to the best of my knowledge, death occured to the best of my knowledge, death occurred to the best of my knowledge to the best of my know	, in my opinion, death occurred at th	e time, date and place, and du	ue to the cause(s) and manner stated.
29b. Signature and title of certifier	29c. License number	29d. Date signe	ed (Month, Day, Year)
I per killa no	00065013	9/1	6/2011

305

3. Time of Death

10d. Inside City Limits

Onset and Death

5 years

Elkton MD 21921

1 Yes 2 No

1:30 PM

Registrar DHMH 17 Rev 7/2009

State

204

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Billon

31. Date filed (Month.

Box 68760 P.O. Division of Vital Records,

State DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

8601 Veterans Hwy

D57531

September (2, 201)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31307 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 16, 2011 Physician/ 6:51 A.M Baggett Floyd. Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3559 Cox Road Calvert Chesapeake Beach Social Security Numb 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😿 M 2 □ F Hours 01/29/1921 South Carolina Director 579-20-2941 90 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3559 Cox Road 20732 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Hygiene. other than "natural", or ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Yes Give Specify: 3 X Widowed 4 ☐ Divorced Year or Dates. WW Completed IIwhite 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th foreman warehouse any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viola Frank Floyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Nancy F. Perfitt, daughter 3559 Cox Road, Chesapeake Beach, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify Metropolitan Crematory 09/16/2011 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, re of Funeral Service Lice is 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one complications of the complete shocks are shocked to the complete shocks and the complete shocks are shocked to the complete shocked to the ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) years Medical Examine Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician are as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death P.O. detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Congestive Heart Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Persemaker 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy Arrhythmas Cerebrovasenlas Insuffrence death? 2 🗆 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this contiline Division of Vital 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 No ᅆ 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

10+1 KW State

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

Gerald P. Sterner,

16 2011

Gendo P. Steves M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

M.D., 19 Chesapeake Beach Rd., E., Owings, MD

D 17245

29d. Date signed (Month. Day, Year

September 16, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 31308 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 9. Physician/ Month 2011 11:44 A M September George M. Farar Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Clinton 6906 Golden Rain Tree Court 8. Date of Birth (Month, Day, April 8 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Days Mir Months Hours Yrs 1946 DC **Director** 577-60-7846 65 Usual Residence of Deceder 28a-f shov 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Clinton Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 United States 6906 Golden Rain Tree Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc.
African þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. American 3 ☐ Widowed 4 🛂 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Meat Cutter other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Applis Clark permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. George M. Farar Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20735 Diane B. Willis 6906 Golden Rain Tree Court Clinton, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2011 4 Donation 5 Other (Specify) Washington National 16, Suitland, Maryland 21. Signature of Fugeral Service Lice 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, Dc 20019 23a. Part 1. Enter the disease, or complications that desed the death. Do not enter the mode of dy shock, or heart failure. List only one cause on sach line. rval Between and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as resulting in death) Last sequence of) physician s the burial Physician/Medical P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did topacco use contribute to the cause of death? 9 Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 25. Was case referred to medica Be filled in by the funeral director 26. Place of Death (Check only one) examiner? 2 🗹 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Accident Natural 5 Pending 1 🗌 Yes 2 \square No 24 hours after death. Funeral Director: A Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur and title of certif 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Laxmi Berwa

SEP 1 9 2011

Date filed (Month,

Clinton, Maryland

20735

7700 Old Branch Avenue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 0 1 1 3 1 3 0 9 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		C	Certifica	ate of	Death			F	Reg. No.			
Physici		1. Decedent's Name (First, Midd	le,Last)						2	2. Date of Dea Month	ath	V		3. Time of Death
Medical Exam	iner	Rachel Joan	n German	l						Septemb	Day er 13, :	2011		0405 hrs
		4a. Facility Name (if not institution		umber)		4	b. City, Town,	or Location	of Death		- 1	County o	f Death	
		Calvert Memorial Hos	pital				Prince Fro	ederick			0	alvert		
Funeral		5. Social Security Number	6. Sex	7. Age (In y	rs. last birth	nday)	If Under 1 Y			8. Date of B	irth(MM/I	DD/YYYY	9. Birtl Foreigr	hplace (State or
Director		217-56-5538	1M 2XF	5	5	Yrs.	Months D	ays Hour	s Min.	4/12	/19!	56	Cou	intry) MD
		Usual Residence of Decedent		L										
' any		10a. State 10b. County		10c. (City, Town	or Locatio	on							10d. Inside City Limits
and show	ř	MD Anne	Arundel				Loth	ian						1 X Yes 2 No
faryls 28a-f	Director	10e. Street and Number					10f. Zip Code	9			10g. Citiz	zen of Wh	at Coun	try?
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	Dir	237 B Stree	et					2071	1			U	SA	
with so 23	ral	11. Marital Status		cedent Ever i	n U.S.		Decedent of				0-	14. Race	- Americ	can Indian, Black,
leath r iten	Funeral	1 Never Married 2 X M	larried Armed F	Forces?	lo.	If Ye	s, specify Cub	oan, Mexicar	n, Puerto R	ican, etc.)		White	, etc.	
	by F	3 Widowed 4 Div	vorced If Yes, Give Ye			1 📗 '	Yes 2 X	No specify	:		l	Specify:	W	hite
ours a		15. Decedent's Education (Spe	cify only highest gra	ide completed	d) 16a. E		s Usual Occu				16b. K	and of Bus		
72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	°	uring mo	st of working I	ife. DO NO I	use retire	a)				
0036 within 72 giene. her than "	Ę	12]	Busi	ness	Owner	c		C	lean	ing	Service
5-0 led w Hygid		17. Father's Name (First, Middle	, Last)		•			18.Mothe	r's Name (F	First, Middle,	Maiden :	Surname)		
21215-0036 ould be filed within 7 Mental Hygiene. s marked other than ic event, the Medica	Be	Guy Lerch		_				Mag	gdale	en Hi	el			
ID 2'should and Me 77 is matter	욘	19a. Informant's Name/Relations		_			Address (Str	reet and Nur	mber or Ru	ral Route Nu	mber, Cit	-		Zip Code)
MD d 2 sho Jth and n 27 is		William Germ	an/Husb				Stre	•						
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours afte ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal f			f Disposit ory or othe	ion (Name of or place)	cemetery,		Date	20c. L	ocation -	City or 7	Town, State
Page lent o	- 1	4 Donation 5 Other S			Zion	Cen	netery	•	9/2	0/11	E11	krid	ge,	MD
Baltimore, MD permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is injury or other traumat		21. Signature of Funeral Serice				22. Na	me and Addre	ess of Facilit	y Ray	bromy	-W0	od F	н	, P.A.
ERGS OD	14	C. Wor				PC	Box	430.	Dun	kirk.	MD	20	754	,
Physician		23a. Fart I. Enter the disease, or		caused the de	ath. Do not									Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease											Death	
Examiner	М	or condition resulting in death) Due to (or as a consequence of):												
		Sequentially list conditions,	b											
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequenc	ce of):									
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687 ertific ding 1	an/	23b. Was decedent pregnant in the past 12 months?	I Live			Feta	l death	3 Ectopi	c pregnanc	СУ		Month	Da	ay Year
Box 687 ne death certific the attending p	Sici	1 Yes 2 V No 9 Uni		nant at time o	rdeath 5	Othe	er (Specify)							
he de the de the de the de f	Physician	Part II. Other significant condit	9 01161		ot rosulting	in the un	dorbina sous	o siyon in D	net I	220 Did 6	obacco i	ico contrib	uito to t	ne cause of death?
, P.O. rres that the signed by be detach	ð	raitii. Other significant condit	iona contributing t	o dealii bul ii	orresulting	in the un	derlying causi	e given in Pa	aili.					ably 4 Unknown
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lec	Completed										rmed? 2 ✔ No		eath? Yes	2 No
Vital Rec ysician: The l his certificate l	Bec	25. Was case referred to medica	i				26.Pla	ce of Death	(Check on	ly one)				
Division of Vital Records, rai or Attending Physician: The law requir is after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	2	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	✓ ER/Ou	tpatient	3 DOA	Other ₄	Nursing I	Home 5	Resider	nce 6	Other:	
n of ding Ph.		27. Manner of Death	28a. Date	of Injury n, Day, Year)	28b. T	ime of Inj	ury 28c. In	jury at Worl	(? 28	8d. Describe	how inju	ry occurre	d	
ion teath. the fi	흹	1 V Natural 5 Pend 2 Accident Inves		.,,,,			1	Yes 2	No					
VISI or Att fter d in by	<u>≅</u>	= -		ce of Injury - A	t home, far	m, street,	factory, office	building, e	tc. 28			nd Numbe	or Rura	al Route Number, City
Dital ours at Illed	Certification:	4 Homicide deter	rmined (Specify)						Į.	or Town, S	state)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri			hysician: To the be											
fo the vithin omple	Medical	one) 2 Medical Exa	miner: On the basis and manner s	of examination	n and/or in	vestigatio	n, in my opini	on, death oc	curred at the	he time, date	and plac	ce, and du	e to the	cause(s)
F × F S	ĭĕ	29b. Signature and title of certifie					29c. Lice	nse number			29d. D	ate signe	d (Mont	th, Day, Year)
0		W-WL					0.0	C.M.E.			Sept	ember	13, 20)11
FW	İ	30. Name and address of person	who completed cau	se of death (I	tem 23a)									
~		Donna M. Vincenti, MI	D Assistant I	Medical Ex	aminer	900 V	V. Baltimoi	re Street,	Baltimo	re, MD 21	1223			
St	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature													
Regist		368 I b 9011	<i>(</i> 0)	B	1									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day GORDY Physician/ 3:15 P M DANIEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MANOR CARE TOWSON 509 EJOPA ROAD 10WSON Baltimore 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex Funeral Age (In yrs. last birthday) Days 1 🔀 M 2 🗆 F 218-20-3907 Director 81 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Randallstown MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21133 9906 Hoyt Circle 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married ☐ Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 African-1 ☐ Yes 2 🔀 No Specify: 3 ☑ Widowed 4 ☐ Divorced American Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Attendant 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Goldie Parker Isaiah Gordy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9906 Hoyt Circle, Randallstown, MD 21133 /niece JeriLynn Reid 20b. Place of Disposition (Name of cemetery, crematory or other place)
Belleville Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 9/11/2011 Suffolk, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Lewis N. Watson Funeral Home, PA
1618 West Rd., Salisbury, MD 21801 21. Signature of Furieral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ PEMENTIA disease or condition resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t 24 hours after death. Funeral Director: After this certificate has been sign 1 🗌 Yes 2 🗌 No 3 🗎 Probably 4 🖫 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Dther: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d, Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of 29c. License number >57722 M.D. TO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 GREENE TREE ROAD #300 PILLESVILLE MD 21208 RICHARDSON LEUNARD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

Records,

Division of Vital

Registrar
DHMH 17 Rev 7/2009

State

Deborah Miller, CRNP

16 2011

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O. 1

Records,

Division of Vital

6001 Muncaster Mill Road, Rockville, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical September 14 2011 Lloyd 2:00 A M Thomas 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2725 Holland Cliffs Road Calvert Huntingtown If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Min. 10-26-1953 Mary Land Director 220-62-7287 57 Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Calvert <u>Huntingtown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2531 Holland Cliffs Road 20639 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene.
item 27 is marked other than '
other traumatic event, the Me Elementary/Seconday (0-12) and 2 should be filed within Health and Mental Hygiene. College (1-4 or 5+) 12 Mechanic Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Everett Hance. Sr Gladvs Alberta Catterton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois A. Hance, Spouse 2531 Holland Cliffs Road, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once, 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Miranda Cemeterv 09-17-2011 | Huntingtown, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. William & Gre-MOO715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque ce of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial-Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No death? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Brother's 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director. After completed filled in by the funeral residence 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of herson who completed cause of death (Item 23a) (Type, Print) drw 238 Merrimac WIL MON 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

P.O. Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#18 per FH State 9/15/2011 aaco. Health Dept. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 200 Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4186 Sands Rd. Anne Arundel Harwood Social Security Number **Funeral** 6. Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months 1 \(M \) a \(\sigma \) Davs Hours Min Feb 27 85 Yrs. ^{ear} 926 Maryland **Director** 214-26-0918 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Harwood 1 ☐ Yes 2🏋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4186 Sands Rd. 20776 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. δ 1 Never Married 2 Married 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3

Widowed 4 □ Divorced Specify: **Black** Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Anne Arundel Co. other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Ō Custodian Public Schools Be Juid be file and mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John H. Parker Emma J. O Emma J. Unobtainable other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Otto Johnson Jr(Son) 4186 Sands Rd. Harwood, Md. 20776 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of the Important: If ite any injury or ot 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Cheltenham Veteran 9-19-11 Cheltenham, Md. Signature of Funeral Service Licenses W Manne a Resease of Facility Sons Mortuary, 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of). Exam or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month 1 Yes 2 No for Month Year Pregnant at time of death Day 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 2 🗌 No 1 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 24 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation M filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрыете (Check Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifie License number (I who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State 5 Registrar

Aaron marquette 11-06897 Jones Pl

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 3 | 3 | 4 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate	of Death		Reg.	. No.				
Physicia Medical Exami		n/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3.									
		4a. Facility Name (if not institution, give street and number Prince George's Hospital Center)	4b. City, Town, o	r Location of Deatl	1	4c. County of Deat Prince Georg				
Funeral Director		220-27-8272 _{1M 2F}	ge (In yrs. last birthday	/) If Under 1 Ye Months Da		_	(MM/DD/YYYY) 9. Bi 1990 Forei Co				
vfaryland 28a-f show any 2 at once.	or	Usual Residence of Decedent 10a. State	10c. City, Town or Lo	ocation heverly		<u> </u>		10d. Inside City Limits 1X Yes 2 No			
ith the Maryl 23a or 28a-l notified at o	Director	10e. Street and Number 6220 Landover Rd.		10f. Zip Code 2	0785	10g	. Citizen of What Cou USA	intry?			
or items	by Funeral	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	? 2 3 No	Was Decedent of H If Yes, specify Cuba Yes 2 X No			14. Race - Amer White, etc.	rican Indian, Black,			
74 3 🗐	Completed t	15. Decedent's Education (Specify only highest grade co Elementary/Secondary (0-12) College (1-4 or 11	5+) durin	edent's Usual Occupa ng most of working life Student			6b. Kind of Business/ Private	Industry			
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) Thomas Ellsworth Jones			Marquita		se	·			
MD 21 ad 2 should ulth and Me m 27 is man aumatic ev	2	19a. Informant's Name/Relationship (Type, Print) Marquita Wise—Jones/Mother	622	0 Landove:	r Rd. Che	everly, M					
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		20a. Method of Disposition 1	tate crematory of Heritage	sposition (Name of ce or other place) • Memorial 22. Name and Addres	Pk 09-2	22-2011	Waldorf, N				
Physician		23a. Part I. Enter the disease, or complications that caused		10583 Mid	dleport I	n. White	Plains, N	AD 20695 Approximate Interval			
Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunsh Due to (or as a const	ot Wounds			, , , , , , , , , , , , , , , , , , , ,		Between Onset and Death			
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated									
executed an and al - transit	cal Exa	events resulting in death) Last Due to (or as a consideration of the con	equence or):								
ox 68760, sath certificate be attending physici or use as the buri		IF FEMALE: 23c. If yes, outco 23b. Was decedent pregnant in the past 12 months? 1 Live birth	me of pregnancy 2 t time of death 5	Fetal death 3 Other (Specify)	Ectopic pregna	ancy	23d. Date of deliver	y Day Year			
i, P.O. Baires that the de signed by the	2	Part II. Other significant conditions contributing to deat	h but not resulting in th	he underlying cause	given in Part I.		cco use contribute to	the cause of death?			
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed					24a. Was an autopsy performs	prior to death?	itopsy findings available completion of cause of			
Vital Rec ysician: The his certificate director, page	a	25. Was case referred to medical examiner? Hospital:	ent 2 🗸 ER/Outpati		of Death (Check		sidence 6 Othe				
ion of Vil tending Physic eath. or: After this the funeral dir	ation: To	1 Yes 2 No Inpatie 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ury 28b. Time	of Injury 28c. Inju	ry at Work? Yes 2 ✓ No	28d. Describe how Subject shot					
Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Certification		njury - At home, farm, s eet	street, factory, office t		or Town, State		ıral Route Number, City er, MD			
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.									
# ¥ # 8	Me	29b. Signature app title of certifier	1	29c. Licens 0.C.		1	9d. Date signed <i>(M</i> o September 13, 2				
5		30 Name and address of person who complete cause of a Russell Alexander MD. Assistant Medic	death (Item 234) cal Examiner 90	00 W. Baltimore	Street, Baltim	nore, MD 2122	3				
Sta Regist	ate rar	SEP 1920 Year) 32. Regista	r's Signature								

11-07086 Connie Sue Jameson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Cei	rtificate	e of Dea	th	~		Reg	ı. No.	* 1	
Physicia	an/	1. Decedent's Name (First, Midd	le,Last)							ate of Death	Day Yea		3. Time of Death
Medical Exami	ner		Connie	Sue	Ja	meson			Se	eptember	20, 2011		1318 hrs
فوري		4a. Facility Name (if not institution St. Mary's Hospital	on, give street and n	umber)			Town, or London nardtown	ocation of De	eath		4c. County of St. Mary		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthda	y) If Un	der 1 Year	If Under 24	Hrs. 8.	Date of Birth	(MM/DD/YYYY	9. Birtl	hplace (State or
Director		214-96-2454	1 M 2 X F		48	Yrs. Mont	ths Days	Hours I	Min. J	une18,	1963	Foreigr Cou	ⁿ ^{intry)} Florida
A.		Usual Residence of Decedent 10a, State 10b, County		Iana Cit.	Town or L								10d. Inside City Limits
ow any		1.52. 554,	.Mary's										1 Yes 2 No
Maryland 28a-f show	횽	10e. Street and Number	rialy S		St.III	igoes	ip Code			100	. Citizen of Wh	at Coun	
or 28	Director		int Look	we Dood		101.2						iai goan	
with the 13 and 13 and 14 and 14 and 15 and		11. Marital Status	12. Was De	cedent Ever in U.	S. 13.	. Was Deced	20684 dent of Hispa	anic Origin?	(Specify		USA 14. Race	- Americ	can Indian, Black,
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be motified at onec.	Funeral	1 Never Married 2 M	arried Armed F	orces?		If Yes, spec	cify Cuba n , I	Mexican, Pue	erto Rica	n, etc.)	White		
H -	by	_	orced If Yes, Give Ye or Dates:		1		2 ^X No						ican Indiar
hours	fed	 Decedent's Education (Spe Eiementary/Secondary (0-12) 		de completed) 1-4 or 5+)				on (Give kind DO NOT use		ione	16b. Kind of Bu	siness/Ir	ndustry
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	12	College (140/34)		Casi	hier				Retail	Sal	es
15-003(filed within Il Hygiene. ed other tha t, the Medic	등	17. Father's Name (First, Middle,	Last)				18	3.Mother's Na	ame (Firs	t, Middle, Ma	aiden Surname))	
← ← □ 2 · ·	å		Amos Ti	ger						Haskir			
MD 212: 12 should be th and Menta 127 is market umatic event	입	19a. Informant's Name/Relations			1						er, City or Town		
, MD and 2 sho calth and cm 27 is	ŀ	Jesse Marie Ja 20a. Method of Disposition	ameson/Dav			sposition (Na			Koa		Inigoe: 20c. Location -		D 20684
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and Iv Important: If item 27 is m injury or other traumatic.		1 Burial 2 X Cremation	3 Removal f	rom State	crematory o	or other place	e)						
Itim it. Pa urtmen ortant		4 Donation 5 Other St. 21. Standard of Funeral Service		r.		polita 22. Name an			7/24/	2011	Атехана	ria,	Virginia
Balti permit. Departri Imports		Muchael XX	Jarolin	eer					iner	Fune	ral Hom	e,P.	Α.
Physician		The Mattingley-Gardiner Funeral Hor 41590 Fenwick Street, Leonardtown, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line.										art	Approximate Interval Between Onset and
`∤Medical Examiner		Immediate Cause (Final disease a. Narcotic (Morphine) Intoxication											Death
		or condition resulting in death)	Due to (or as a	a consequence of	f):								
	ē	Sequentially list conditions, if any, leeding to immediate	Due to (or as	a consequence of	f):								
	Examine	(Disease or injury that initiated	C. Due to (or se	a consequence of	r\.							-1	
uted id ransit		events resulting in death) Last	d.										
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8760, ificate be up physici	ΣI	IF FEMALE: 23b, Was decedent pregnant in th		outcome of pregr							23d. Date of		
an 4 00 m	ian	past 12 months?	Live	oirth nant at time of dea		1		Ectopic pre	gnancy		Month	Da	ay Year
Box 687 ne death certific the attending 1	Physiciar	1 Yes 2 No 9 Unk	snown 9 Unkn		2 □	Other (Spe	есіту)						
ires that the signed by the detache		Part II. Other significant conditi	ions contributing t	o death but not re	esulting in t	the underlyin	ig cause giv	ren in Part I.	- :			_	he cause of death?
S, P	ed by								- L			Proba	ably 4 🗹 Unknown
cords law requi	Completed								_	24a. Was an autopsy	, р	rior to co	opsy findings available ompletion of cause of
Record The lagrange True la page 2	E								1	perform ✓ Yes 2		eath? ✔ Yes	2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	Managhali —					f Death (Che	ck only o	ne)			
Physic r this	္ပ	1 ✓ Yes 2 No 27. Manner of Death		Inpatient 2					rsing Hor			Other:	
Division of Vital Records, talor Attending Physician: The law requires after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the fineral director, page 2 should the fineral director.	ö	1 Natural 5 Pend		n, Day,Year)	28b. Time	:30 am	28c. Injury	s 2 K No	1	CNOWN	w injury occurre	ea .	
isiO Atter er deat rector	īcat	2 Accident Inves	tigation 28e Plac	-20-11 se of Injury - At ho			I		28f I	ocation (Str	eet and Numbe	r or Rur	al Route Number, City
Cital or urs after Illed in	Certification:		not be mined (Specify)		siden		,,	3.	Rd.	or Town, Sta	te) 15248- nt Inig	-A Po	int Lookout
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use at	Medical C	29a. Certifier 1 Certifying Pt	nysician: To the bearing						and due t	o the cause(s) and manner	as state	d.
To T	Med	29b. Signature and title of certifie	and manner s				c. License				29d. Date signe		
		The ode MI	16:01 -1				O.C.M	.E.	OCME		September	21, 20	011
	-	30. Name and address of person	who completed cau	se of death (Item	23a)								
		Theodore M. King, Jr.,	_	ant Medical E		r 900 W	. Baltimo	ore Street,	Baltim	ore, MD	21223		
St Regist	ate rar	31. Date filed (Month, Day Year)	2011 R	egistrar's Signatu	re	w							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEP 1²2^y ŽÖ'1 1 12:32 AM DONNA JEAN KOZAK Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death MONTGOMERY WALTER REED NATIONAL MILITARY MEDICA BETHESDA 7. Age (In yrs. last birthday) 53 yrs. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Hours 139-48-1747 Amityville, Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at 10c. City, Town or Location Director Harpers Ferry W۷ Jefferson 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral USA 25425 832 Deer Mountain Drive items ? hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: If Yes, Give Year or Dates White "natural", Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "1 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jean Florence Meiselbach Donald Thomas Spengeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 832 Deer Mountain Drive, Harpers Ferry, WV 25425 . Page 1 and 2 sl tment of Health a tant: If item 27 i: jury or other tra Steve Kozak - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date cemetery, crematory or other place)
Hagerstown Crematory 1 Burial 2 X Cremation 3 X Removal from State 9-19-2011 Hagerstown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Eackles-Spencer
Harpers Ferry, 21. Signature of Funeral Service Licenses Norton 25425 Funeral Home 100970 WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ ISCHEMIC INFARCTION Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or iinjury that in the cause) Due to (or as a consequence of): Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2X No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2X Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown OVARIAN CANCER Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an TAKOTSUBO CARDIOMYOPATHY page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No မှ 1 Nation 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 124 hours after death e Funeral Director: A Investigation completed filled in by the 6
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License numbe 29d Date signed (Month, Day, Year VA 0102202876

Registrar

8

State

egistrar's Signature

WALTER REED NATIONAL MILITARY MEDICAL CENTER BETHESDA MD 20889 5600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CPT DO

Year) 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frank Knight, Jr. September 2011 23:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 3 **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1 🗷 M 2 🗆 F Hours Min. 1<u>923</u> 422-16-7677 Country) Alabama 88 **Director** Jan. Usual Residence of Decedent 10a. State 10c. City, Town or Location be notified at 10d. Inside City Limits Director 28a-f Md. 1 X Yes 2 No Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a (must be Funeral 4037 Olney-Laytonsville Road 20832 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 🗷 Yes 2 🗆 No 1942-14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Divorced 4 Divorced 1945 Black. Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Officer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Knight, Sr. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Lucretia H. Knight / Wife 4037 Olney-Laytonsville Rd., Olney, Md. 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If ite any injury or ot Date 1 🔀 Burial 2 🗆 Cremation 3 🔲 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 9/17/2011 Laurel, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038. Laytonsville, Md. 23a. Part 1. Enter he lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death of Cir Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Year signed by the a d be detached f Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed 1 Tes 2 🗌 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ည 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending (Month, Day, Year) To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Afte completed filled in by the fun 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ata Motamedi, M.D. 17904 Georgia Avenue, #304, Olney, Md. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KHANOM Month 9:30 AM 2011 Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 05 SILVERSPRING LITTL ETON STREET MONTGOMER Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 577-11-1906 1 □ M 2 💢 F (Month, Day BANGLADESH **Director** 80 Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD MONTGOMER' SILVERSPRING 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 3905 0 ITTLETON ANGL ADESH filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 ₩ Widowed 4 □ Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOME MAKER Be 17. Father's Name (First, Middle, Last) should be filed and Mental H is marked of 18. Mother's Name (First, Middle, Maiden Surname, မှ ABBAS ND-DIN ABIDA KHANOM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🗸 🗸 704. permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra SON 705 ITTLETON ST. SILVERSPRING 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of, Exami the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the tuneral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 Yes Other: မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation М 1 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20855 JOSEPH M.D 6001 MUNCASTER State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 1 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Ce	ertificate	of Dea	ath		,,3,	Reg. No.			
Physici Medical Exam		Decedent's Name (First, I Wendy Lunn	Middle,Last) Lesueur	Wendy I	umn I	o Co.			2. Date of Do	eath		.]	3. Time of Death
misulcar Exam	mer	4a. Facility Name (if not inst		_	-уин г			Location of Dea	Month Septemi		2011 c. County o		1824 hrs
		3720 Pinewood Co		a mambery				e Beach	ati i		Calvert	Death	
Funeral Director		5. Social Security Number 577–86–4866	6. Sex	7. Age (In yrs.		y) If Un Mon Yrs.	nder 1 Yea					9. Birti Foreigi Cou	nplace (State or n intryMaryland
		Usual Residence of Decede	nt						1	.,			
W any		10a. State 10b. Cou	•	10c. Cit	y, Town or L		-	,					10d. Inside City Limits
yland -f sho once	호		vert		Ches	apeak		icn					1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 3720 Pinewo	od Court			10f. Z	ip Code 207	'32		10g. Cit	izen of Wha	at Coun ISA	try?
h with t ms 23s	uneral	11. Marital Status		Decedent Ever in ted Forces?	J.S. 13.		dent of His	spanic Origin? (10-	14. Race	- Americ	an Indian, Black,
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Щ	1 Never Married 2 3 Widowed 4	Married 1 Ye Divorced If Yes, Give	es 2 X No	1	Yes		n, Mexican, Puer specify:	to Ricari, etc.)		White		ite
ours a	d by	15. Decedent's Education (Specify only highest	grade completed)	16a. Dece	edent's Usua	al Occupat	ion (Give kind o		16b. l	Kind of Bus		
	Completed	Elementary/Secondary (0-	12) Colleg	ge (1-4 or 5+)		ig most of w USTOME		DO NOT use re	etired)			NASZ	٨
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21215 uld be file Mental Hy marked o	Bec	Thomas Jenk							hyllis :				
221 hould I hould Wer is mar	2	19a. Informant's Name/Relat			19b. Ma	ailing Addres	ss (Stree	t and Number or				, State,	Zip Code)
MD and 2 sho alth and m 27 is		Steven E. Le	Sueur/Spo										4D 20732
Baltimore, MD 2 pernit. Pages I and 2 shou Department of Health and I important: If item 27 is in injury or other traumatic		20a. Method of Disposition 1 Burial 2 Crema	ition 3 Remov	al from State	Place of Dis	r other place	e)		Date			•	own, State
Baltimo permit. Page Department of Important: injury or oft	2	4 Donation 5 Othe	Specify:	FC	-				/30/201	1 Br	entwo	od,	Maryland
Balt permit. Departi Import		21. Signature of Funeral Ser	Cleri	ille	1367	2. Name an 6512	NW C	rain Hw	Beall Fi	ie, l	MD 20	715	
Physician /Medical		23a. Part I. Enter the disease failure. List only one ca	, or complications the use on each line.	at caused the deat	h. Do not ent	er the mode	of dying,	such as cardiac	or respiratory a	rrest, sho	ck, or hear	t	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final dise or condition resulting in deat		odone Int		tion							Death
		Sequentially list conditions,	b	as a consequence	or):								
	Examiner	if any, leading to immediate cause. Enter Underlying Car (Disease or injury that initiate	ise	as a consequence	of):								
uted id ransit	Exa	events resulting in death) La	st Due to (or a	as a consequence	of):							- 7	
760, icate be executed physician and the burial - transit	Medica	X UNPENDED		1 per 1 7,28a-f,	ne g92 per me	0 10 <u>–</u>	11-11 11-	18 <mark>-1</mark> 1 sm	n				
8760 ificate ig phys		IF FEMALE: 23b. Was decedent pregnant	23c. If ye	es, outcome of preg	gnancy		- [230	d. Date of d	-	V
Box 68760, i death certificate by the attending physical for use as the bur	sician	past 12 months?	4 Pr	egnant at time of de	2 eath 5	Fetal death Other (Spe		Ectopic pregn	lancy		Month	Da	ay Year
Bo he dea	Phys			ıknown							,		
of Vital Records, P.O. ng Pbysician: The law requires that the After this certificate has been signed by meral director, page 2 should be detach	Ď	Part II. Other significant con	ditions contributin	g to death but not a	resulting in th	ne underlyin	g cause gi	iven in Part I.		_		_	ne cause of death?
ords, w require s been sig	Completed						_		24a. Was				ppsy findings available
COF law r has b	du						_		auto	psy ormed?	pri		mpletion of cause of
tal Rec		25. Was case referred to med	ical				26 Diese	of Dooth (Choole	1 Yes	2 N	1	✓ Yes	2 No
/ital	Be	examiner?	Hospital:	Inpatient 2	ER/Outpati	ent 3 I		of Death (Check Other ₄ Nursi	ng Home 5	Reside	nce 6 🗸	Other:	Scene
ing Phy	2	1 ✓ Yes 2 No 27. Manner of Death	28a. Da	ate of Injury onth, Day, Year)	28b. Time			y at Work?	28d. Describe				DOCTIO
ion trendir leath. for: A	atio			9-23-11	fd 6:	15 pm	1 Y	es 2 X No	unknowi	1			
Division tal or Attendi rs after death. al Director: A	Certification:	3 Suicide 6 X 0		lace of Injury - At h	ome, farm, s		y, office bu	uilding, etc.	28f. Location or Town,	(Street a State) 3	nd Number 720 P	or Rura	Route Number, City
15 P. D. S.		29a. Certifier (Check only) Certifying	Physician: To the			_	e time, dat	te and place, and					
To the Howithin 24 h To the Fu	Medical		xaminer: On the bas and manne	sis of examination a er stated.	and/or investi				at the time, date				
	2	29b. Signature and title of cer	ifier			29	c. License	4 -	p = pm				h, Day, Year)
		Thurlen	Mr Fen	of TR.	mi	1	O.C.N	/I.E.		Sep	tember 2	24, 20	11
0		30. Name and address of persons. Theodore M. King,		ause of death (Item stant Medical E	,	900 W	. Baltim	ore Street F	Baltimore M	D 2122	23		
	ate			Registrar's Signatu									
Regist	rar	31. Date filed (Month, Day, Ye SEP 27	2011	eur A.	bar	Kel							

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Shirley June Lowe 2011 14. 1:30 AM September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🕱 F Months Days Hours October 1930 Chicago, IL 80 **Director** 360-22**-**0744 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 K No MD Montgomery Chevy Chase 10e. Street and Number r items 23a or ner must be n ò 10f. Zip Code 10g. Citizen of What Country? Funeral 8100 Connecticut Ave., #909 20815 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 X Widowed 4 Divorced Specify: Caucasian the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Charles R. Harriet Golda Lewis 1 and 2 should by Health and Meinten 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Lowe, Son 7000 Hillcrest Place, Chevy Chase, MD 20815 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Information of Informa 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Fort Lincoln Crematory 9/20/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, 2085 of Funeral Service Licensee M01102 KOUT 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between nset and Deat weeks Immediate Cause (Final Ph, sician/ aLeft frontal bbe and right temporal stroke disease or condition Medical resulting in death) Examiner Severe Chronic obstructive Pulmonary disease 3 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Examir Coronary Artery disease 30 years and Due to (or as a consequence of): resulting in death) Last Physician/Medical 09/89 d.Hyper lipidema 30 years IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Myelodysplactic Syndrome 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? Yes 2 K No 1 ☐ Yes 2 🕱 No 25. Was case referred to medical Vital Be 26. Place of Death (Check only one) Other: 2 X No 1 Yes မ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) o 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 1 🛚 Natural 5 Pending Division Accident
Suicide 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A completed filled in by the t Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D71517 September 15, 2011 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natalia Maria Vasqueez Martinz 8600 Old Georgetown Road, Bethesda, Maryland 20816 31. Date filed (Month, Day, Year) State 16 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 14, 2011 7:20 am Milton Emerson Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Columbia Howard Gilchrist Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New Jersey Months Days 1 X M 2 🗆 F 08/09/1920 91 **Director** 226-14-9075 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Farnham Virginia Richmond 1 Yes 2 X No 10e, Street and Number 10f, Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral u.s.A. 22460 5105 Farnham Creek Road death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc ō Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 27 is marked other than "natural", traumatic event, the Medical Exa Specify Black 3 X Widowed 4 Divorced Year or Dates Decedent's Education. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Je filed wn... *al Hygiene. '`⊶r than "r (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) Farming should be filed with and Mental Hygien 7 is marked other to Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Hannah Jackson Martin Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Elkridge, Maryland 21075 Ameika Bush - Granddaughter P.O. Box 8565. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory: 09/21/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinalli Funeril Home, Inc. Signature of Funeral Service Licensee M1564 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PROBABLE COLON CANCER WEEKS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed l 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, HUPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? CORONAMY ARTEMY DISEASE 24a. Was an has autopsy performed? page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 🗷 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director. / Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D64395 SEPTEMBER 14. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA, MO 21044 DANIEUL DOBERMAN, MO 31. Date filed (Month, Day, Year) **SEP 1 6 2011** 32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

AMEND#1Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 3 3 2 2										
			Registrar 9/15/2011 AACO HEALTH DEPT. ONH Certificate of Death 1. Decodorité Name (First Middle Loct) 1. Decodorité Name (First Middle Loct)							
Physic Med			Luis Martin	is Guer.	rero Ma	rtin	2. Date of De Month		3. Time of Death	
1 State of	Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of [
Europal			1363 ESCAPADE CT RIVA ANNE AR 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 If Under 24 Hrs. 8. Date of Birth 9.							
	Director 223–56–9041 1X M 2 □ F 81				Yrs. Months Days Hours Min. 01/15/1930				Birthplace (State or Foreign Country) PAIN	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ţ	10a. State 10b. County 10	c. City, Town or Loc	ation				10d. Inside City Limits	
		Dire	MARYLAND HOWARD 10e. Street and Number	ELLICOTT	ICOTT CITY 10f. Zip Code				1 ☐ Yes 2 🖾 No	
		To Be Completed by Funeral Director	3206 OLD FENCE RD		21042			10g. Citizen of Wha	t Country?	
e, Maryla			11. Marital Status 12. Was Decedent Ever		as Decedent of H	ispanic Origin? (Spe	cify Yes or No-	14. Race - A	American Indian,	
			1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Yes 2 □ No Specify: SPANISH			Specify	Black, White, etc.	
			Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busines					HITE		
			(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Clieve kind of work done during most of work done dur			during most of workir	ng	MEDICINE		
			17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)							
			EUGENIO GUERRERO MEDALLA 19a. Informant's Name/Relationship (Type, Print)	19h Mailin	JOSEFA MARTIN 19b. Mailing Address (Street and Number or Rural Route Numb					
			EUGENE D. GUERRERO-MARTIN/SON	1		, BALTIMO			, ZIP C00e)	
				20b. Place of Dispos	ition (Name of		ate	20c. Location - City	y or Town, State	
			4 Donation 5 Other (Specify) CENTER CREMATION 09/15/2011 STEVENSVILLE, MD							
Ba	Depar Impo any ir		21. Signatur of unazil service Licensee	HE.	Name and Addres LFENBEIN A 814 B	SS Of Facility LAS'	TINGT	RIBUTES BY NAPOLIS,	ERALLOWS:	
	Physician/ Medical Examiner	hysician/	233 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Approximate Interval Between inset and in the cause of the condition of the c							
	I or Attending Prlysician: The law requires that the death certificate be expended and are death certificate has been signed by the attending physician if in by the funeral director, page 2 should be detached for use as the buriance.		Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last b. Due to (or as a consequence or). C. Due to (or as a consequence of):							
P.O. Box 68760			d							
			in the past 12 months?	23c. If yes, outcome of pregnancy 1					delivery Day Year	
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?							
rds		eted	1 Yes 2 No 3						robably 4 ☐ Unknown	
Division of Vital Records,		Certificate: To Be					24a. Was autor perfo 1 Yes	osy prior	e autopsy findings available to completion of cause of h? Yes 2	
			25. Was case referred to medical examiner?			ace of Death (Check		2 2 2 4 4 0 1 1 1	165 242,910	
			1 Inpatient 2 ER/Outpatient 3 DOA Outer 4 Nursing Home Standard 6X Other (Specify) Parchter's 27. Manner of Death 28a, Date of Injury 28b, Time of 28a Injury 28b,							
			1 Natural 5 Pending (Month, Day, Year) Injury work? 1 Yes 2 No						Nesice De	
Divisi			3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - 1 building, etc. (Sp.	At home, farm, stree necify)				(Street and Number or Rural Route Number, own, State)		
		Medical	29a. Certifier (Check only one 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		— r	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day Year)							
			D0064379 913/11							
1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar SEP 1 5 2011 Registrar's Signature SEP 1 5 2011									
	State Registra	400	31. Date filed (Month, Day, Year) 32. egistrar's S	ignature 1	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. 14, Day 2011 Helen R. Murrill 8:15 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Crofton Care and Rehab Crofton Anne Arundel 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth

(Month, Day, Y 9. Birthplace (State or Foreign **Funeral** Months Year 1919 Director Arkansas 579-14-0774 91 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or items 23a or 28a-4-shou 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Davidsonville 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2531 Cheval Drive 21035 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced Specify: White injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) F.A.A. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank S. Ripley Atha Florence Dowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Heater - Son 2531 Cheval Drive, Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🐒 Burial 2 🗌 Cremation 3 🔲 Removal from State Lincoln Cemetery 9-20-2011 Donation 5 Other (Specify) Brentwood, MD 21. Sign 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Rhysician/ OSC disease or condition Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l page 2 s autopsy death? 24 hours after death.

Funeral Director, After this certificate 1 ☐ Yes 2 ☐ No Yes funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29d. Date signed (Month. Dav. Year) 20/08 who completed cause of death (Item 23a) (Type, Print) Name and address of person ANTFOXLNH222 BOWLEMD 300GALL 31, Date filed (Month, Day, Year, State SEP 1

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09/ Day 11/ Y2011 Richard Mercer McCormick, Jr. 10:00 a_M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Center ClintonPrince George's Social Security Number 8. Date of Birth (Month, Day, Year) 10/01/1945 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days 1 X M 2 D F Hours Min. **Director** 65 220-42-4526 28a-f show 10a. State with the Maryland 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Prince George's Clinton 1 Yes 2 No 10e. Street and Number ō 10g. Citizen of What Country? 10f. Zip Code Funeral items 23a 9604 Glenview Drive U.S.A. 20735 Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

Sant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black White etc Completed by 1 XNever Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2 🗶 No 1 ☐ Yes 2 🕱 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Planner Department of Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard M. McCormick, Sr. Blanche Bozard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James McCormick, Jr./Nephew 2220 Harley Drive, Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Important: It any injury or Lee Crematory 09/15/2011 4 Donation 5 Other (Specify) Clinton, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licensee Dedry J. Goff 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Atherosciente Cardiovascular Disense disease or condition resulting in death) /temp Medical Due to (or as a consequence of) **Examiner** Acute Gasmintenna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit severe Anemic Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Disbeten Mariams Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Huperten sin 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 You To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) C D50689 09/13/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Southern manyland Huspitel certa Winter MD drw MD 31. Date filed (Month, Day, Year) 32. Registra s Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Elizabeth Netch September 10, 2011 8:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death 2454 Bear Den Drive Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💥 🖪 Months Days Hours Dec. 15, 1921 089-12-0422 89 Director Washington Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 🖺 Yes 2 🗌 No ě 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 23a Funeral 2454 Bear Den Drive 21701 "natural", or items 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working marked other than life. DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) 2 William David Britt, Sr. Lillian Victoria Forsland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doug White / Son-in-Law 19208 Ranworth Dr., Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of Sept. 2011 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory Frederick, Maryland 21. Signature of French Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. Skkot Cody P.A. Frederick, MD 21701 23a. Part 1. Enter the disease shock, or heart failure. Li s, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Demention Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Impory that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Dav Year signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No eral Director, After this certificate | filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🖊 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direc Medical 29a. Certifier Descritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar 9.12.11

3

State Registrar egistrar's Signature

Fredenos, 202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. 12 Day 2011 Tatiana Popova 1551 Medical 4a. Facility Name (if not institution, give street and number) PTEMBER Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Rockville If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Days Hours 272871952 578-23-1924 59 Latvia **Director** Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Potomac 28a-f Montgomery 1 🗆 Yes 2 🎦 No 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? be ms 23a Funeral with 1 7905 Crestdale Drive 20854 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) d Mental Hygiene. marked other than "natural", or iter matic event, the Medical Examiner. 14. Race - American Indian, Black, White, et Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Victor Semenov Alexandra Churkina Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Vassili Popov/Husband 7905 Crestdale Drive Potomac, Md 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rock Creek Cem 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 9/15/2011 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) PHTTTPAdos RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ respirator tai lure disease or condition Medical resulting in death) Due to (or is a consequence f): Examiner co 11050 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due (or as a consequence of and L thyroid concer metastatic Due to (or as a consequence of): nding physician a Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery atter in the past 12 months?

1 Yes 2 No ☐ Live Birth 2 ☐ Fetal 3000 ☐ Pregnant at time of death ☐ Unknown for Day Year 1 Yes 2 Dunknown the signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available To the Hospital or Attending Physician: The law page 2 s has autopsy prior to completion of cause of death? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No ပု 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director, After completed filled in by the funeral 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eniquelle. MD 71325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland Ushakiran Yenigalla, MD 31. Date filed (Month, Day, Year) State 16 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 31327 State
Registrar Certificate of Death Rea. No. 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) - 1<u>3</u>, Month Physician/ 6:00 PM 2011 Evelyn Gray Pinkard September Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Hebrew Home of Greater Washington 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** July 17 1 M 2 F Months D.C 87 Director 578-24-3054 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State with the Maryland must be notified at Director 1 ☐ Yes 2X No 01ney Montgomery 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 0 Funeral USA items 23a 20832 18301 Georgia Avenue, Apt. 314 death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Medical Examiner Black, White, etc. White Armed Forces?

1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes No Specify If Yes Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) during most of working Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Services Schools 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ruth Weimer Rixey Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18301 Georgia Avenue, Apt. 314, Olney, MD 20832 James K. Pinkard/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Sept. 15, 4 Denation 5 Other (Specify) Metropolitan Crematory Alexandria, VA 2011 ignature uneral Sewice Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Trehard - Actor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner as the burial-tlagsit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 🔲 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown After this certificate has been signed by the truneral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed death? 1 Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 KNursing Home 5 Residence 6 Other (Specify 1 Yes 2 X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npleted filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29d. Date signed (Month, Day, Year, 29b. Signatu 29c. License numbe 00062263 Sept. 15, 2011 e and address of person who completed cause of death (Item 23a) (Type, Prin tem 23a) (Type, Print) 196, TJD RIVE, PREDEMCE, MD 130 Date filed (Month, Day, Year) State 16

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ September 14, 2011 3:58 Romayne Bell Perritte Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring 3946 Rickover Road Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country 1 M 2 XF Months Days Hours Min. Feb. 12, Year 1923 188-12-9993 88 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 1 ☐ Yes 2 🖾 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 20902 USA 3946 Rickover Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🛣 No Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. 3 Midowed 4 ☐ Divorced Year or Dates traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Oil Company Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Floy Miller Joseph Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3946 Rickover Road, Silver Spring, MD 20902 Alan Victor Perritte/Son Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Sept. 2011 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD of Funeral Service Licensee Francis Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 20 yrs Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the otherwise and the contract of the contrac the attending physician and hed for use as the buridatesit Diabetes Mellitus that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Month Pregnant at time of death signed by the a Id be detached f 1 ☐ Yes 24 9 ☐ Unknown 9 I Inknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed?
1 Yes 2 No 1 ☐ Yes 2 ☐ No in 24 hours after death.

he Funeral Director: After this certific pleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home State Residence 6 Other (Specify) ျှ 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practionery of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Sept. 15, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13018 Georgia Avenue, Wheaton, MD 20906 Francisco Matheus, MD

State

Registrar

31. Date filed (Month, Day, Year)

16 2011

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 31329

		1- For State Certificate of Death Reg. No.													
Physici	an/	1. Decedent's Name (First, Midd	le,Last)								Date of De Month		Year		3. Time of Death
"cal Exami	ner		Glen	Ryan Pri	<u>ice</u>						Month Septemb				0637 hrs
		4a. Facility Name (if not institution		umber)			. City, To		cation of	f Death			County of		
		11960 Browning Cour					Monrov						ederick		
Funeral		Social Security Number	6. Sex	7. Age (In yrs. la	ast birthd	ay)	If Under Months	1 Year Days	If Under	Min.				Foreign	
Director		214-17-3280	1 X M 2 F	31	1	Yrs.	IVIOITA IS	50,0	riodio		May 19, 1980			Cou	ntry) Maryland
		Usual Residence of Decedent		140 0"											10d. Inside City Limits
w any		10a. State 10b. County		10c. City,	Iown or					- 1	1 Yes 2 X No				
Maryland 28a-f show d at once.	5		ederick_					rov	ia						
ne Maryland nr 28a-f sho fied at once.	Director	10e. Street and Number					10f. Zip C	ode				10g. Citize	n of Wha	at Count	ry?
h the	ﻕ	11960_	Browning_						770					USA	
h wit	Funeral	12. Was Decedent Ever in U.S. Armed Forces? Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.											 Race - White, 		an Indian, Black,
r deal nrit	ᆲ	Never wallied 2 Mailied 1 Yes 2 X No													
s afte	ò		Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify: Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done											Whi iness/In	
"natu	Completed	Elementary/Secondary (0-12)								use retired		102.14			
36 hin 72 than	륄	12													uction
d with	5	17. Father's Name (First, Middle,	, Last)							s Name (F	irst, Middle,	Maiden St			decion
215 e file tal Hy ked o	Be	н	arry S. P	rice						Gina	a LaSo	ola E	rice	e	
213 Suld b Men Men	2	19a. Informant's Name/Relations			19b. I	Mailing A	Address	(Street a	and Num		al Route Nu				Zip Code)
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica		Gina L. Price,	Mother		119	960	Brown	ning	Cou	rt, N	Monrov	via, N	1D 2	1770	
		20a, Method of Disposition			crematon	v or othe	on (Name		etery,		Date	20c. Lo	cation - (City or T	own, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If itel		1 Burial 2 X Cremation		rom State	M€	etro	DO11t	an	_	Sent	25 20	11 1	lovai	ndri	a. Virgina
litir nit. P artme sortas		21. Signature of Funderal Service Licerisee / 22. Name and Address of Facility													
Dep De linju		Molesworth-Williams, P.A., Funer 26401 Ridge Road, Damascus, MD 2											mera D 2	al H 0872	ome
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that	caused the death	. Do not e	enter the	mode of	dying, su	uch as ca	ardiac or re	espiratory a	rrest, shock	c, or hear	rt	Approximate Interval Between Onset and
/Medical ∈xaminer		Immediate Cause (Final disease	77	Intoxi	catio	ori									Death
Examine		or condition resulting in death)		a consequence o											
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(a) Se = =	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence o	of):		-						•		
ecuted and and transit			d	22- 27 (20 . (. 0.04	0 10	2 11					
760, cate be exe physician he burial -	√Medical	X UNPENDED		23a,27,2		, pe	r me,	g921	0 10	-3-11	L sm	Lan			
44 60 50		IF FEMALE: 23b. Was decedent pregnant in t		outcome of preg birth		Feta	l death	3	Ectopic	pregnanc	:y		Date of o	delivery Da	ay Year
Sox 687 leath certifi e attending of for use as t	cia	past 12 months?	4 Preg	nant at time of de		_	r (Specif								
Box 68 te death certi the attendin	Physicial	1 Yes 2 No 9 Un	known 9 Unkr	iown											
P.O. s that the greed by e detach	by P	Part II. Other significant condit	tions contributing	to death but not r	esulting i	n the un	derlying c	ause giv	en in Pa	rt I.			_	_	he cause of death?
o o								-		_					ably 4 Unknown
ords, w requir s been s	Set										24a. Wa auto	psy	pr	nior to co	opsy findings available empletion of cause of
ecc he lav ate ha	Completed											ormed?		eath? ✔ Yes	2 No
tal Recian: The certificate ector, page	Be C	25. Was case referred to medica					26			Check on					
Vit.	0	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outp	patient	3 DO	A O	ther ₄			Residen			Scene
of ing P After unera	n: T	27. Manner of Death	28a. Date (Mont	e of Injury h, Day,Year)	28b. Tir	me of Inj			at Work		8d. Describe		/ occurre	ed	
ion trend leath. tor:	atio	1 Natural 5 Pending Fd 9-20-11 fd 6:25 am 1 Yes 2 No unknown													
Division of Vital Records, and retained the law requirater death. In order death. In precent. After this certificate has been seled in by the funeral director, page 2 should be	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural or Town, State) 1 1 9 6 0 Brown												al Route Number, City ming Ct.	
Di spital hours a neral I	Š	4 Homicide determined (Specify) residence Monrovia, Md.													
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. The the Funeral Director: After this certificompletely filled in by the funeral director,	ical	29a. Certifier 1 Certifying P	hysician: To the beaminer:On the basis	est of my knowled of examination a	ige, death and/or inv	occurre estigatio	ed at the ti on, in my c	me, date pinion, d	e and pla death occ	ce, and du curred at t	ue to the ca he time, dat	use(s) and e and plac	manner . e, and dı	as state ue to the	cause(s)
To t with The t	Medical	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)													
	_	O.C.M.E. September 20, 2011													
		30. Name and address of person	who completed car	use of death (Item	n 23a)										
			sistant Medical			. Baltii	more St	treet, E	Baltimo	re, MD	21223				
S	tate	31. SEP 3 0 th 20 y Year)	32. R	legistrar's Signat	ure										
Regis		SEP DU ZUIT	Leneva	8. So	a proper de	P									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#17pFH, 9/22/11; EWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:55p M Sebt. 1 Pay 201 Tear Luis Jose Rouge Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 F Days 579-72-7177 60 4 126 14 951 Spain **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No MD Montgomery Silver Spring 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20910 Spain 9615 Dewitt Drive #107 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
item 27 is marked other than "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🖾 Yes 2 🗆 No Specify: Spaniard White If Yes, Give 3 ☐ Widowed 4 🔀 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Construction Contractor Be 17. Father's Name (First, Middle, Last) Rouco 18. Mother's Name (First, Middle, Maiden Surname)
Carmen Vasquez ೭ Miquel Ogera Rouca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9615 Dewitt Drive #107 Silver Spring, Md2091 Leticia Rouco/former wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place)
Chesapeake Crem. 9/15/2011 Beltsville, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Ligen PHIP TO REMALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Onset and Death Physician/ Cirrhosis due to alcohol Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami Cause (Disease or linjury that initiated events sician and burial-trans resulting in death) Last Physician/Medical e attending phys... IE FEMALE 23c 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown signed by the a Part II. Other significant conditions contril þ Completed page 2 should 25. Was case referred to medical Be examiner? 2 **X**No မှ 27. Manner of Death Certificate:

Records, P.O. Box 68760

The law requires that the death certificate by Division of Vital within 24 hours after death.

Jo the Funeral Director: After this certific U-completed filled in by the funeral director, the the

1 Natural

2 Accident
3 Suicide
4 Homicide

only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year

SEP

30. Name and address of person who comp

29a. Certifier (Check

Medical

5 Pending

Investigation 6 Could not be determined

Certifying Physicia

Steven Wilk

Medical Examiner:

Certifying Nurse Pi

16 2011

Due to (or as a consequence of):								
	Ectopic pregnancy Other (specify)	-1	23d. Date of delivery Month Day Year					
uting to death but not resulting in the u	nderlying cause given in Part I.		acco use contribute to the cause of death?					
		24a. Was an autopsy perform	ed? death?					
	26. Place of Death (Che							
al: 1 Inpatient 2 ER/Outpatien	ot 3 DOA Other: 4 Nursing H	lome 5 Residen	oce 6 Other (Specify) hospice					
Ba. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 \(\sum \) Yes 2 \(\sum \) No	28d. Describe how	injury occurred					
Be. Place of Injury - At home, farm, streen building, etc. (Specify)	eet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To the best of my knowledge, death on the basis of examination and/or invest ctioner: To the best of my knowledge, or	tigation, in my opinion, death occurred	at the time, date and	place, and due to the cause(s) and manner stated					
- 21	29c. License number	29	d. Date signed (Month, Day, Year)					
the ms	D0063195		Sept.11,2011					
eted cause of death (Item 23a) (Type, P $= MD - 6001$ M	r _{int)} Muncaster Mill	Rd Rock	cville,Md					
32 Registrar's Signature	Med							
ORIGII	NAL							

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:45 A^M 09 Bruce Albert Rudolph 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 24 St. Michaels Court E1kton Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Min 179-32-1059 69 **Director** 1 🏝 M 2 🗆 F 4/6/1942 PA 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 ☐ Yes 2X No MDCecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 24 St. Michaels Court 21921 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Courier Health Care traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be a Department of Health and Ments Important: If item 27 is marked Harry Rudolph Frances Paynter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Rudolph - wife 24 St. Michaels Court, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State ō Important: It any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) R.T.Foard Funeral Home, PA Rising Sun. MD 21. Signature Ineral Service Licenses 22. Name and Address of Facility R.T. Foard Funeral Home, PA East Main Street, Elkton, MD 21921 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Ph_sician/ disease or condition resulting in death) Aspiration neumon Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). attending physician and a for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 certificate has performe 2 No Yes 2 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending Natural Natural death. 1 Tes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after o determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier W MD D0062190 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2533 AUGUSTINEHERMANHWY, SUITEA, CHESAPEAKECITY, MD21915. SHAHNAWAZ KHAN 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-201

State Registrar

VD

		-	State of Registrar	Maryland	d / Depa		t of H	ealth a	and Mer		iene U	1 1	313	32
			Registrar 1. Decedent's Name (First, Middle, Last)						2.	Date of Deat	1		3. Time of	Death
	Physicia	an	WILLIAM T. RUSSELL, JR.						s	Month EPTEMB	ER 15	Year 2011	8:05	p^{M}
	/Medic Examin		4a. Facility Name (If not institution, give street and num.			4b. City,	Town, or	Location of	of Death		4c. County			
300		·.	310 Hickory Lane			Cru	ımpt	on			Queen			
	Funeral Director		5. Social Security Number 6. Sex 1 1 ★ M 2 □ F 7	'. Age (In yrs. I	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min. Ma	Date of Birth (Month, Day, ay 13,	^{Yea} r) 1923	Ri che Dela	ace (State of MZ)dson ware	Park
	put		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	ocation						10	Od. Inside C	ity Limits
	faryla f sho	ъ											1 ☐ Yes	XX No
	the N	Director	Maryland Queen Anne's 10e. Street and Number		Crumpt	10f. Zip	Code			1	0g. Citizen of	What Coun	try?	
	3a or		310 Hickory Lane				2162	8			United	l Stat	es	
	death ms 2	Funeral	11. Marital Status 12. Was Deced	lent Ever in U.S	S. 13.	Was Deced	lent of H	ispanic Ori	igin? (Specif	y Yes or No- an, etc.)		ce - Americ		
9	after or ite		1 ☐ Never Married 2 🔯 Married 1 🔯 Yes 2	² □No A r π	ny	1 □Yes 2		Specify:		,	1	fy: Whi		
003	ural",	d b	3 ☐ Widowed 4 ☐ Divorced Year or Da	tes: 1943 -		dent's Usua		otion			16b. Kind of E	Rusiness/Inc	tustry	
15-	"nati	lete	15. Decedent's Education (Specify only highest grade completed)		(Give	kind of wor DO NOT us	rk done d	during mos	t of working		TOD. TAILE OF E	200110007111	audit y	
12	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Madical Examiner must be notified at	Completed by	Elementary/Secondary (0-12) College (1-12)	4or 5+) 2		truct: uperi			ct		Cons	struct	ion_	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)					18. Moth	er's Name (F	irst, Middle, I	Maiden Surna	me)		
<u>la</u>	should be f and Mental I s marked of umatic eve	To E	William Thomas Russell,	Sr.						arie C				
lar)	s 1 and 2 should if Health and Mer item 27 is marke other traumatic	1	19a. Informant's Name/Relationship (Type. Print)								r, City or Tow		Code)	
	1 and 2 Health tem 27 i		Susan D. Mercer / Daught	er							aryland 20c. Location			
Baltimore,	ges 1 t of H if itel		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from S	tate No.	Place of Disponent Place of Disp	Strion (Ivar	reed Teed	:e)	Septen	nber	North 1	-		and
tim	t. Par rtmen rtant; njury		4 □ Donation 5 □ Other (Specify)	Met		2. Name ar	_		28, 20)II I				- Table
Bal	permit. Pages 1 and 1 Department of Health Important: If item 27 any Injury or other tr		21. Signature of Fungral Provide Limits		1	27 So	uth	Main	Stree	t, Nor	eral Ho th Eas		land	21901
,092	Physician Medical Examiner Permit is transit Are prival-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		uence of):				s cardiac of r	espiratory an	esi,		Approxima Interval Be gnset and	etween I Death
.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medi		oirth 2 🗍 Feta nant at time of o	al death 3	☐ Ectopic ☐ Other (s		ey .				Date of delive	ery Day	Year
٥,	s that med b e deta		Part II. Other significant conditions contributing to de						I.	23e. Did to	bacco use co			
rds	en sig	ed b	Mypertensian, GERD	3/41	1 coma	7 90)	1.241	1		1 🗆 Y	es 2000	3 Pro	bably 4] Unknown
I Records,	sician: The law requir certificate has been s rector, page 2 should	Completed by								24a. Was autop perfor		o. Were auto prior to co death? 1 🗆 Yes	opsy finding ompletion of 2 No	s available cause of
/ita	cian: ertific ctor,	Be (25. Was case referred to medical examiner?				Lou		e of Death (Check only o	ne)			
) t	Physic this c		1 Yes No Hospital: 1 □ 1	npatient 2	ER/Outpation		OA Otr 28c. Inju				lence 6 0		ify)	
on (ding F	ion	Natural 5 Pending (Mont	th, Day, Year)	Injury	M	Wo	rk?]Yes 2[d. Describe i	iow injury ooo	unou		
Division of Vital	I or Attendi after death. Director: A	rtifical	3 ☐ Suicide 6 ☐ Could not be 28e, Place	of Injury - At h ng, etc. (Speci	l ome, farm, s ify)	treet, factor				of. Location (S City or Tov	Street and Nu	mber or Rui	al Route Nu	ımber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certification: To	29a. Certifier (Check only 2 Medical Examiner: On the b	asis of examina	owledge, dea	ath occurred	d at the t	ime, date a	and place, ar	nd due to the	cause(s) and date and plac	manner as e, and due	stated. to the cause	e(s)
	the thin 2 the f	Med	one) and mani	ner stated.		29	 c. Licen	se number			29d. Date sig	ned (Month	, Day, Year))
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	0		30. Name and address of person who completed caus		m 23a) (Tvn	e, Print)	, ,	00 (, , ,		111	111		
	8		Dr. Fred Delboy, MD,6602	Churcl	h H i 11	Road	, Su	ite 2	200, C	hester	town,M	ary1a	nd 216	520
Ī	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 1 2011	legistrar's Sign	ature and	N								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 11, 2011 Physician/ 6:30 Ам Charlie L. Rivers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's District Heights 3000 West Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Sex 1 M 2 □ F Funeral Days (Month, Day, Year) 1937 Months Hours Min North Carolina 237-52-3331 Director 73 Usual Residence of Decedent or 28a-f shov 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No District Heights Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3000 West Avenue 20747 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2
No Specify. **Black** Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event at once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Office Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lemo L. Rivers Melissia Struill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 Clover Smith-Rivers - Wife 3000 West Avenue District Heights, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State September Clinton, Maryland Lee's Crematory 4 Donation 5 Other (Specify) 19, 2011 21. Signature of Funeral Service Licen ee 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Anemia Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Chronic Obstructive Pulmonary Disease attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnam 9 ☐ Unknown cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🖾 Yes 2 🗆 No 3 🗆 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 🖾 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 🔲 Yes 2 🗌 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours a To the Funeral L Medical 🕇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

Sisom Osia,

Sound

9 2011

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9628 Marlboro Pike

32. Registra 's Sign

29c. License numbe

D48158

Upper Marlboro, Md.

29d. Date signed (Month, Day, Year)

20772

September 14, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygien 2 1 | 25 per me, g920, 10/12/2011dbb Centificate of Death State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AMES TOWARD 900 M 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 M 2 🗆 Jul. 9. 1923 219-14-5420 Director 88 Yrs. Maryland Usual Residence of Decedent 28a-f shov death with the Maryland 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🗐 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12621 Safety Turn 20715 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 194
If Yes, Give 10 14. Race - American Indian, Black, White, etc. 0 à 1 Never Married 2 Married 2 □ No 1943-Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. "natural" Completed 3X Widowed 4 □ Divorced Specify 1945 White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Principal Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alan H. Skidmore Julia Friend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13413 Idlewyld Drive, Bowie, MD 20715 Janet Alessandro -Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Boxial 2 X Cremation 3 ☐ Removal from State Metro Crematory 9-16-2011 Baltimore, MD 4 Donation 5 Other (Specify) Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ INTRACRANIAL MORRHAGO disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Exami MEDICAL EXAMINER The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-transit and CERTIFICATION APPROV Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: ' 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Investigation 2 Accident Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifi Name and address of person who completed cause of death (Item 23a) (Type, Print) NNAPOLIS M DN401 DEFENSE distrar's Signatur State SEP 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 12, 2011 3:20 Mary G. Schreiber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 13307 Global Street Bowie Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday, **Funeral** Months Days Hours **Director** 87 399-38-3443 1 M 2 XX 11-5-1923 Minnesota Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location items 23a or 28a-f shoner must be notified at Director 1XXYes 2 No Prince George's Bowie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 13302 Global Street Bowie death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status an "natural", or ite Medical Examiner Armed Forces? Black, White, etc ☐ Never Married 2 ☐ Married þ permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XX No Specify: If Yes Give XX Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Assistant Retail of Health and Mental Hygi item 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lizzie Thonenes Frank Jesinoski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 13302 Global Street, Bowie, Md. 20720 Koep - Son Duyane 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State wisconsin Memorial 9/21/2011 Brookfield, Wisconsi Robert E. Evans Funeral Home 4 ☐ Donation 5 ☐ Other (Specify) Brookfield, Wisconsin Signature of Funeral Service Licensee 22. Name and Address of Facility 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the doubth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Due to (or as a consequence of): Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician do be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. been signature should be 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 has autopsy death?
1 Yes 2 No perform ours after death.

eral Director; After this certificate I filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 🗌 Nursing Home Residence 6 🗍 Other (Specify) 2 No 0 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident 6 🗆 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Narse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signatur and title of 29c. License number 29d. Date signed (Month, Day, Year) 226

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Mont)

back

Good look bed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 5 2011

47

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 13 3011 Physician/ Month 2:0/ A M Kenneth Warren Shelton SEPTEMBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign OCCT. 16, 1935 Washington, DC If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) sex 1 XI M 2 □ F Days Hours 579-46-0408 Director 75 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No Maryland Prince George's Greenbelt 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 65907 Cherrywood Lane Apt 202 20770 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 0 þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Warehouse Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Stewart Shelton Vernoll M. Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 65907 Cherrywood Lane Apt 202 Greenbelt, MD 20770 Barbara Shelton/ Wife Baltimore, 20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c, Location - City or Town, State cemetery, crematory or other place. Memorial opail 4 ☐ Donation 5 ☐ Other (Specify) 9/20/2011 Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ espirato disease or condition resulting in death) Medical Due to (or as a consequence of) discose **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury inding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown (Tuphocy he 24b. Were autopsy findings available prior to completion of cause of death? v Cluna 24a. Was an this certificate has autopsy performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospita _2 🛂 No ၉ 1 🗌 Yes Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Funeral Director: After or pleted filled in by the funeral Director. Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral D Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29h Signature and title of certifi MDD 606 11

DHMH 17 Rev 7/2009

State

Registrar

COAD

LAWHAM, MD

3118 GODS LICK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ND.

ASFAW,

SEP 1 5 2011

SAMUEL

31. Date filed (Month, Day, Year)

AAC) Health	ret	t. 9–14–11 KAH For State Registrar	State of	Marylan	-	artment of F tificate of L		nd Mental Hy	giene 0	1 31337			
	Physicia	ın/	1. Decedent's Name (First, Midd						2. Date of De Month Sept.		3. Time of Death 111 12:00 P M			
	Medic Examin	cal	Jerry Lee S 4a. Facility Name (if not institution		er)		4b. City, Town, or	Location of		07, 20				
			445 McBrid					rna Pa		Anne	Arundel			
	Funeral Director		5. Social Security Number 232-50-4208	6. Sex 1 X M 2 □ F	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days			04,1933 W	B. Birthplace (State or Foreign Country) Sest Virginia			
	aryland a-f show fried at	ector	Usual Residence of Decedent 10a. State 10b. County MD Anne	Arundel		y, Town or Lo	ation a Park				10d. Inside City Llmits 1 ☐ Yes 2X No			
	ith the Mi 23a or 28 at be noti	Funeral Director	10e. Street and Number	Tana			10f. Zip Code 2114			10g. Citizen of Wh	at Country?			
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		445 McBride 11. Marital Status 1 □ Never Married 2 X Ma 3 □ Widowed 4 □ Divorce	12. Was Decede Armed Force 1 X Yes Cive	es? No	1		ispanic Origir n, Mexican, F	1? (Specify Yes or No- Puerto Rican, etc.)	14. Race -	American Indian, White, etc. White			
21215-0036	rithin 72 hou iene. r than "natu the Medical	Completed by	15. Deced (Specify only high Elementary/Seconday (0-12)	ent's Education lest grade completed) College (1-4	or 5+)	(Give life, D	lent's Usual Occup. kind of work done of O NOT use retired) Builder	during most o	_	16b. Kind of Business Industry Arundel Builders				
Maryland 2	d be filed w fental Hygi irked other tic event, i	To Be	17. Father's Name (First, Middle, Napoleon Spa	Last)				18. Mother's	s Name (First, Middle, a Skaggs					
, Man	id 2 should salth and N n 27 is ma er trauma		19a, Informant's Name/Relation: Robert Sparks						or Rural Route Numbe Severna I					
Baltimore,	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other				sition (Name of natory or other place National Cemetery	ľ	Date unk	20c. Location - C				
Balt	permit. Depart Import any inj		21. Signature of Funeral Service	Licensee		B 4	Name and Address arranco & 95 Ritchi	s Sons Le Hwy	P.A. Sev Sev	erna Park erna Park	Funeral Home , MD 21146			
	Ph, sician/ Medical		23a. Part 1. Enter the disease shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each	line. 280	scle	r the mode of dying	g, such as ca	RDIO VI	rs culvi	Approximate Interval Between Onset and Death			
	Examiner	er	Sequentially list conditions,	ь Нурез	as a consequ rtens as a consequ	ion			Dise	rge	- MONTHS			
	ate be executed bhysician and the burial-transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c	as a consequ	860	Ention				Tenys			
09,	ate be o	edical		d										
Box 687	ath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		th 2 ☐ Feta ntattime.ofo	al death 3	Ectopic pregnand Other (specify)	бу		23d. Date Montl				
ls, P.O.	requires that the de been signed by the should be detached	ed by Ph	Part II. Other significant condit	ions contributing to deat	th but not res	sulting in the u	nderlying cause giv	ven in Part I.		Deg.	ute to the cause of death?			
Division of Vital Records,	sician: The law req	Completed by								psy pri- ormed? de:	ere autopsy findings available or to completion of cause of ath? Yes 2 \sum No			
ital	ician: certific ector,	Be	25. Was case referred to medica examiner?	Hospital:			Oth	or:	(Check only one)					
n of V	nding Phys tth. : After this (e funeral dir	cate: To	1 X Yes 2	28a. Date of		ER/Outpatier 28b. Time of injury	28c. Injury	4 ∐ Nurs yat	(dence 6 Other				
Divisio	tal or Attendi 's after death. 'al Director: A ed in by the fu	l Certificate:	3 Suicide 6 Could	not be 28e. Place of	Injury - At ho , etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (City or Tou		or Rural Route Number,			
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2 Medical only one) 3 Certifyir	g Nurse Practioner: To	of examination	n and/or inves	tigation, in my opinio death occurred at the	on, death occu e time, date a	urred at the time, date	and place, and due to ne cause(s) and mann	o the cause(s) and manner stated. ner as stated.			
	vit or cor		29b. Signature and title of certification of the second se	- R Anja	mia	ms	29c. License	number 1693	4	_ :	29d. Date signed (Month, Day, Year)			
	HOLL		30. Name and address of person			1 23a) (Type, F			3ALTIMOV					
	Sta Registra		31. Date filed (Month, Day, Year)	5 2011 32. Reg	istial s Olyila	Luic								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #23bper PHY #23e

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3 | 3 | 3 | 8

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 13, 2011 Ralph Wallace Sheehy 1:45 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Sunrise Assisted Living Frederick Funeral 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Months Wonth Day, Year 1914 New York Days Hours Min. 96 070-03-7439 **Director** Nov. Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland 1 🗌 Yes 2 🙀 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 9045 Spring Valley Drive 21701 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 2 ☐ Yes 2 K No 1 ☐ Yes 2 X No Specify: Specify: White If Yes Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Director of Public Relations Mainframe Computing 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Fester Timothy H. Sheehy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $6508\ Springwater\ Ct.\ \#3302$, Frederick, MD 21701 Tim Sheehy / Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Sept. Date 4, 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 2011 21. Signature of Funeral Service Licensee Resthated of the rail Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. 2 a. Part I Inter the disease shock, or if art failure. Immedia ause (Final disease or condition Interval Between Onset and Death .Physician/ avdiomyo Medical resulting in death) Due to (or as a consequence of): Examiner ementia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) burial-transit resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year 1 Yes 2 GUnknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 2 🗌 No 1 Yes Yes 2 funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 - Pending 1 Natural 1 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) corr pleted filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9-13-11, D60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

temen

Day, Year)

14

31. Date filed (Month.

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Mom

32 Fegistrar's Signature

Frederick MD Z176)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) September 24, 2011 Physician/ 12:20 A M Fave Alene Thornton Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Frederick Airy Mount Kline Hospice House 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday, Year If Under 24 Hrs. **Funeral** June 8, 1927 Montana Hours Min 517-24-8503 84 **Director** 1 □ M 2 🛛 F Usual Residence of Deceden 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. Count er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Directo 1 Yes 2 X No Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21703 5653 Sandy Court 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 X Married 2 Maryland 21215-0036 1 ☐ Yes 2X No Specify White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Clinical Research Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Program Financial Officer and Mental Hygier is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alma Buck <u>Perlev Ray McKnight</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is it any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 5653 Sandy Court, Frederick, Maryland 21703 Kern D. Thornton / Husband Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 1 XBurial 2 Cremation 3 Removal from State Mount Ölivet Cemetery Frederick, Maryland 27, 2011 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Keeney and Basiord PA Funeral Home 106 E. Church Street, Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Ph_{sician}/ ears disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician do be detached for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months?

1 Yes 2 X Yo

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown No Division of Vital Records, To the Funeral Director: After this certificate has been signate. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 **X**No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Dath 28b. Time of 28d. Describe how injury occurred Medical Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d, Date signed (Month, Day, Year) 29b. Signature ap 30. Name and address of person W

Registrar
DHMH 17 Rev 06-2011

State

11-06718 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Teon L. Wallace State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Medical Examiner 1102 hrs Teon L. Wallace September 6, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) Months Days Hours Director oreign Moaumy)1and 212-35-2937 Nov 8 1991 1X M 19 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No or items 23a or 28a-f show Maryland Anne Arundel Annapolis must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Hicks Ave 21401 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married _ Yes 3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: Black "natural", ੬ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "1 is marked other than 0 Cashier McDonald's 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Charles Wallace Jr Demetria Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia R. Hicks(Grandmother) 14 Hicks Ave Annapolis, Md. 20a, Method of Disposition 20b. Ptace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State njury or other 1 X Burial 2 Cremation 3 Removal from State Memorial Park 9-13-11 Annapolis, Md. 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 2Willime and 色色等をf FacilitySons Mortuary, 1922 Forest Dr. Annapolis, Md. 21401 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medica Death a. Gunshot Wound of Back Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED by the attending physician ached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the att page 2 should be detached for 1 Yes 2 No 9 Unknown Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical uneral director, 26 Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) Sep 6, 2011 After 27. Manner of Death 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot 1 Natural 1031 hrs within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Pending 1 Yes 2 V No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 101 S. President Street, Annapolis, MD determined (Specify) Local Street 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated Sa 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 7, 2011 30. Name and address of person who completed cause of death (Item 23a) Russell Álexander MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day nistrar's Signatur State 5 2011 parke ween Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O 9 2:47 A M Physician/ 2011 William Walter Waugh Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Wi comico oastal Hospice At the Lake ISBUIL If Under 1 Year | If Under 24 Hrs.

Months Davs Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F 6/28/1925 86 PA 195-16-8835 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Examiner must be notified at Director 1 Yes 2 No Ocean Pines MD Worcester 10g. Citizen of What Country? 10f. Zin Code 5 10e. Street and Number 23a Funeral 21811 IISA 134 High Sheriff Trai1 "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: white 3 Wldowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Media Times 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Catherine Bowman George Waugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21811 OCean Pines, MD 134 High Sheriff Trail, Joan Waugh / wife William 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place, 1 🗆 Burial 2XI Cremation 3 🗀 Removal from State First State Crem. 9/16/2011 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee MD 21811 108 WIlliam St., Berlin, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BM BN Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) Exami and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) n signed by the a Id be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 3 Probably 4 Unknown Completed page 2 should peen 24a. Was an autopsy To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has! 1 🗆 Yes 🔎 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 10058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1733 SALISBURY UP

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Rehistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Ttem 27d Per med cff of Health and Mental Hygiene Reg. N20 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2011 1950 6 Anne Wimbrow 9 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Snow Hill Worcester Harrison Senior Living Snow Hill Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1□M 2XF 9-25-1924 Ohio Director 167-20-4385 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director Snow Hill MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 301 S. Church Street 21863 death 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify.White 1 ☐ Yes 2 X No Specify: Saltimore, Maryland 21215-0036 ģ 3X Widowed 4 Divorced "natural", 16b. Kind of Business/Industry Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Clerk 11 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Della Eden John H. Dyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1706 Holly Swamp Rd, Pocomoke City, MD 21851 Sharon East/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place C Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 9-13-2011 Dover, DE Direct Cremation, 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 21. Signature of Funoral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Heart Failure Immediate Cause (Final Congestive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Arteny Disease Examine CORDINER / Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IE FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Tyes 2 No ed by the a 9□Unknown 9 Unknown s been signed by the should be detach. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy page 2 performed' 2 No Attending Physician: ector, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Hospital: Other: 4 Varsing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA ۴ funeral dir After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Medical Certification: Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 ☐ Accident the 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral C completely filled is 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00063253 Cly de Erwert Liet) m 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9-7-11 428 w. Market 5%. Snew 4. U, mo 21863 Style Ennest Gibb Ja M. D.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month Stays Year) 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 21,2011 12:35P M HARRY HOWARD WOLFE 3RD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 9. Birthplace (State or Foreign Country)
Maryland Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours July 23 1 XM 2 □ F 82 1929 Director 579-30-5857 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Frederick Adamstown 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 21710 5431 Mountville Road items 72 hours after death . Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give . 0 þ 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: White "natural", Year or Dates. 146-149 3 Divorced 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Entrepreneur Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (F.rst, Middle, Maiden Surname) ဂ္ Mary Rose Clagett Harry H. Wolfe, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trau 5431 Mountville Road, Adamstown, Maryland 21710 Mary Wolfe / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place Resthaven Memorial Gardens 26. 2011 Frederick, Maryland Keeney and Bastord PA Funeral Home, The Church Street Frederick, MD 21701 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ cancer Lung disease or condition Medical resulting in death) Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) g physician and as the burial-transit executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death signed by the a d be detached f Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 잍 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending after death. Director: Af 1 Yes 2 No Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifie 21 2011 person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

21

30. Name and add

Date filed (Month, Day Year)

Rizvi

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400 West

lay.

28a-f show

death with the Maryland

hours after

21215-0036

Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

31344 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Medical Examiner Thomas Yoder 1340 hrs September 23, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Counfy of Death University Hospital **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6 Sex If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Director Months 375-26-7625 Hours 1 M 2 F 07/26/1930 Country) Michigan Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Crofton 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1620 Farnborn Street 21114 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1X Yes 2 4 Divorced If Yes, Give Year Vietnam or Dates: 1 Yes 2 No specify 2 Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 honer of Health and Mental Hygiene.
ant: If item 27 is marked other than ""
or other traumatic event, the Medical E. College (1-4 or 5+) 12 Analyst U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bennivennel H. Yoder Minnie Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris M. Yoder/Spouse 1620 Farnborn Street, Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Lakemont Mem. Gardens 09/28/2011 Davidsonville, Maryland Donation 5 Other Specify o Funeral Service Lice 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. /Medical Between Onset and a Intra-Oral Gunshot Wound Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f, per me, $g_{920} 10-3-11 \text{ sm}$ IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? 2 Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed

The law requires that the death certificate be Box 68760, <u>о</u>. Records, To the Hospital or Attending Physicisn: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director; 1 Division of Vital

and

the attending physician ed for use as the burial

signed by the

After this certificate has been a funeral director, page 2 should

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g

State

Registrar

25. Was case referred to medica

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

examiner?

1 🗸 Yes

27. Manner of Death

Accident

Homicide

29a. Certifier (Check only 1

3 X Suicide

30. Name and address of person who completed cause of death (Item 23a)

5 Pending

SFP 2 7 2011

Could not be determined

Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 egistrar's Signature

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Found: Residence

fd 8:00 am

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24a. Was an

Other Nursing Home 5 Residence 6 Other

Crofton, Md.

26.Place of Death (Check only one

28c. Injury at Work?

29c. License number

O.C.M.E

1 Yes 2 X No

autopsy

performed'

28d. Describe how injury occurred

subject shot self

✓ Yes 2 No

24b. Were autopsy findings available

death?

28f. Location (Street and Number or Rural Route Number, City or Town, State) $1629\ Farmhorn\ St.$

September 24, 2011

29d. Date signed (Month, Day, Year)

1 🗸 Yes

prior to completion of cause of

2 No

pare

Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year)

and manner stated.

fd 9-23-11

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical **Examiner** Town, or Location of Death a last birthday) 8. Date of Birth **Funeral** Birthplace (State or Foreign Months Days (Month, Day, **Director** Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral New 40 21222 Was Decede.
Armed Forces?
Ves 2 No Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed lac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Q 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) aughte 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City of Town, State 1 🔲 Bunal 2 🛱 Cremation 3 🗆 Removal from State 5 Other (Specify) 4 Donation Treenmount 21. Signature of Funeral Service Licensee any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k the funeral director, page 2 autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 29/2011 Physician/ Allen Lester 4:10p Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3811 Annapolis Rd. Baltimore Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 72 Months Days Hours 216-32-5447 09/05/1939 Director Georgia Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryland notified at Director MD Baltimore Baltimore 1 Tyes 2 X No 10e Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 3811 Annapolis Rd. 21227 USA be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Tow Service Recovery Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev 0 James Allen Estelle Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannie Berrios / Step-daughter 3811 Annapolis Rd., Baltimore, MD 21227 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. W. Arundel Crematory 09/30/2011 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 M01452 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician rananu disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be and 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ☐ Pregnam ☐ Unknown be detached signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed page 2 1 Yes 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medica examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending Work: 1 ☐ Yes 2 ☐ No ☐ Accident Investigation completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R125828 9/30/2011 evos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OHMH 17 Rev 7/2009

State

Registrar

158f. Ste 4105, Brut more MD 2120

Lews, CRNP 6201

32. Registrar's Signature

31. Date filed (Month, Day, Year)

OCT 0 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10/2/2011 Physician/ 30 Dorothy Marie Balzer Medical 4c, County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Sykesville 4831 Cherry Tree Lane 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Security Number 7. Age (In yrs. last birthday) Funeral Months Days Min. Country) 1 □ M 2 🍱 F 471571924 MD 212-58-1066 87 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10a. State Director r 28a-f sh notified 1 Yes 2XX No Sykesville Carrol1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be Funeral USA 21784 4831 Cherry Tree Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Bon Secours Hospital R.N. 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Catherine Inglehart Joseph P. Balzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4831 Cherry Tree Lane, Sykesville, MD 21784 Patricia Davis/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from State 10/6/2011 Baltimore, MD New Cathedral Cem. 4 Donation 5 Other (Specify) of Funeral Service Licensee 21. Sig Burrier Outer Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Inter the disease, or complications shock, or heart failure. List only one cause Immedia e Cause (Final Pnysician/ UPEIS disease condition resulting in death) Medical Examiner Sequentially list conditions, Examiner If any leading to incredict cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the sold be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 s certificate has t lirector, page 2 s 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 A No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29d. Date signed (Month: Day, Year) 29b. Signature and atle of certifie 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1702PM Wdette 2011 chae Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** raltin Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Yea If Under 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 Months Days 69 215-38-6507 Director 1942 Marvland Aug Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location must be notified at 28a-f 1 X Yes 2 No Maryland Montgomery Damascus ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a Funeral 9804 Beall Ave. 20872 U.S.A. items 2 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", Completed 3 Widowed 4 XDivorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 county government accountant other traumatic event. Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Hazel Williams Merle Burdette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trait New Windsor, MD 21776 2922 Old Liberty Rd. Joyce Burdette/ ex-wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 9/29/2011 Sykesville, MD AllCounty Cremation 21. Sign Proof Funeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home P.O. Box 249 New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ uncon disease or condition Medical resulting in death) Due (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine CEMMICALIAN RAPROPED BY MEDICAL ELANIMES Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit and Due to (or as a consequence of): nding physician Physician/Medical death certificate be Box 68760 as IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Por in the past 12 months? Month Day Year Pregnant at time of death signed by the at d be detached for 2 No Yes P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed within 24 hours after death.

To the Funeral Director: After this certificate 2 No Ya 1 Ves filled in by the funeral director, 25. Was case referred to medical 2 lace of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗌 No 1 🖾 Inpatient 2 🗆 မ ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred Certificate: 28b. Time of 28c. Injury at work? iniury 5 Pending Natural Accident unknown death to spirm Cord into 28f. Location (Street and Number or Rural Route Number,) 1 - Yes 2 - No Investigation 9/12/11 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Dator Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) andva 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 0 3 2011 Registrar

DHMH 17 Rev 7/2009

		An	Pleas nend #25, per ME g 1- For Registrar	e Type or Pr i 919 9/29/1 State of Ma	I TT aryland / Dep	ndelible Inkartment of F	x. Ensure All Copi Health and Mental F Death	es Are Legible. lygien@ ()	31349							
	Physic		1. Decedent's Name (First, Middle, La	st) parella		amouto or i	2. Date of Month	Death Day Year	3. Time of Death							
)	/Medi Examii		4a. Facility Name (If not institution, given Johns Hopkins Bayvi		Center	4b. City, Town, or Location of Death 4c. County of Death Baltimore										
	Funeral Director			Sex 7. Ag	e (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of (Monte, 3)	Birth 9. Bi Bay, Year) 25/1945	rthplace (State or Foreign buntry) MD							
	Maryland -f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore	10c. City, Town or Lo		undalk		10d. Inside City Limits 1 ☐ Yes 💢 No							
	h with the 23e or 28a st be notifi	Funeral Director	10e. Street and Number 7232 German Hi	ll Road		10f. Zip-Code	1222	10g. Citizen of What C	ountry?							
980	72 hours after death with the Maryland netural", or items 23e or 28a-f show tical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 XX If Yes, Give Year or Dates:	So I	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XXIIo	lispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - Am Black, Whi Specify:								
21215-0036	within 72 hours ene, than "netural", he Medicai Exa	Completed	15. Decedent's E (Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4 or 5	(Give	DO NOT use retired	during most of working	16b. Kind of Busines								
Maryland 21	be filed tral Hygi od other event, ti	To Be Co	17. Father's Name (First, Middle, Last) Roland S. We	0 esterfield		Homer	maker 18. Mother's Name (First, Mid Helen		,							
	permit, Pages 1 and 2 should I Department of Health and Meni Importent: If Item 27 is market any injury or other treumatic e once.		19a. Informant's Name/Relationship (Patricia C. Cap		ughter 62	22 Shipv		ore Maryland	21224							
Baltimore,	, Pages 1 tment of H tent: If iter jury or oth		20a. Method of Disposition 1	(y)	Ardent	crematory or other place	8/28/2011		aryland							
Ball	permit, F Departm Importer any injur		2 Signature of Funeral Service Licer		15		ss of Facility Stevens Funer ct Avenue, Balt									
	Physician		23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	e. atory Fa		ng, such as cardiac or respirato	y arrest,	Approximate Interval Between Onset and Death 5days							
200	/Medical Examiner	er	Sequentially list conditions, if at y, leading to inviscotion cause. Enter Underlying	b. Centra	a consequence of): 1 Herniati a nonsequence of:	00			3days							
	s executed an and urlal-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o. Intrac		emorrh		CAL EXAMINER	Bdays							
8760,	icate be e physiclan s the burk	edical		BYCHEDICAL EXAMINE												
O. Box 6876	siclan: The law requires that the death certificate be excertificate has been signed by the attending physician irector, page 2 should be detached for use as the burit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	CERTIFICATION APPROVED	23d. Date of d Month	elivery Day Year									
ds, P.	uires that I signed by	by	Part II. Other significant conditions of	· ·		underlying cause g		id tobacco use contribute ☐ Yes 2 ☐ No 3 ☐ F	to the cause of death? Probably 4 AUnknown							
Reco	The law req te has been bage 2 shou	Completed	Diabetes M	ellitus				utopsy prior to erformed? death?								
l Vita	s certificat director, p	To Be C	25. Was case referred to medical examiner? 1 XYes 2 No	Hospital: 1 1 Inpatie	nt 2 ☐ ER/Outpatier	nt 3 DOA Oth	26. Place of Death (Check one er: 4 ☐ Nursing Home 5 ☐ R		ecify)							
Division of Vital Records, P.O.	to the Hospital or Attending Physician: within 24 hours after death as a fire death to the Funeral Director. After this certifica completely filled in by the funeral director,	Certification: 7	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injui (Month, Day	y 28b. Time o	f 28c. Injur Worl M 1 🗆	k? Yes 2 □ No	be how injury occurred n (Street and Number or	Rural Route Number,							
ă	Hospital or A 24 hours after Funeral Direc etely filled in b		4 ☐ Homicide determined 29a. Certifier 1 ★ Certifying Ph	building, etc ysician: To the best o	c. (Specify) f my knowledge, deat	n occurred at the tir	City or ne, date and place, and due to	Town, State) the cause(s) and manner	as stated.							
	To the Hospital or within 24 hours afte To the Funeral Direct completely filled in	Medical	(check only one) 2 ☐ Medical Example (check only one) 2 ☐ Medical Example (check only one) 29b. Signature and title of certifier	niner: On the basis of and manner sta	examination and/or in ited.	vestigation, in my o	opinion, death occurred at the ti	me, date and place, and d								
			30. Name and address of person who	Reside			-000	August 2	4,2011							
	Sta		Shawnigus 31. Date filed (Month, Day, Year)	W.Iliam			4940 Eastern	Avenue, Baltim	ore, MD, 21224							
	Registr	_	SEP 2 9 2	011 Senen	~ B. p.	ares										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2030 Carrington 2011 Delore S /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Grace Hartoro Co 5015 Union Ave Harve Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗹 F 213-30-2801 3 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show ortant; if item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Madical Examinar must be rediffed at 1 ☐ Yes 2 No Director Hartord 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Specify: Black 1 Never Married 2 Married 1 ☐ Yes 2 No \$ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Decements obtail occupation (Give kind of work done during most of working life. DO NOT use retired)

Janitorial Elementary/Secondary (0-12) College (1-4or 5+) Jomestic 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be is marked of 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Dr Pages 1 and 2 Health a SON arrington 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ArliNgton National 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee aberdeen South 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): Examiner DYSLIPIDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CHRONIC KIDNEY DISEASE, STAGE III death certificate be executed the burial-tran Due to (or as a consequence of) DINBETES MELLITUS, TYPE 2 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 🔼 № 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page CE MAKER 1 ☐ Yes 2 ☐ No 2 Nt Vital 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2. ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier lew Mondrowser uso D08096 SEPTEMBER 26,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW NOWHROWST! MD 35 FULFORD ME. BEZMR, MP2/0/4 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a, 27, 28b, e.f., per me, 2920 10-17-11 sm. State of Maryland / Department of Health and Mental Hygiene for State Registrat Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ PM ratere 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore C Baltimore 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State of If Under Foreign Social Security Number 7. Age (In yrs. last birthday, Funeral Country) PA 1 1 M 2 □ F Days Hours 127571937 Min 217-34-6876 73 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10h County 10c. City, Town or Location Director must be notified 1 Yes 2XX No MD Carrol1 Eldersburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 23a Funeral 6602 MacBeth Way 21784 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or items or items 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give 1055-5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Year or Dates 1955-59 Specify: item 27 is marked other than "natural", other traumatic event, the Medical Exal White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Clifton T. Perkins Hospital Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Rita Bartol Joseph Cameron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6602 MacBeth Way, Eldersburg, MD 21784 Mary Linda Cameron/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State Carroll Crematory 9/21/2011 Winfield, MD 4 Donation 5 Other (Specify) 21. Signature of Europal Section Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do notice the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Multiple Injuries Medical Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY LIFE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Ď Pregnant at time of death signed by the ar Yes Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 ♠No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autops death? s after death.

Director: After this certificate! Yes 2 No 1 Yes 2 No 25. Was se referred to medical examiner?

1 1 Yes 2 No or Attending Physician: funeral director, 26. Place of Death (Check only one) Be Other: ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify 27. Manner of Death 28b. Time of unk 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: . Year Natural Accident 5 Pendina _+ 15/2011 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Price of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e 28f. Location (Street an Number or Rural Route Number, filled in by determined 6602 To the Hospital within 24 hours To the Funeral Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Proclioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certi D53724 (Month, Day, Year) 29c. License number 29d. Dale signed 01 20 w Dr. Jiminez 30. Name and address ted cause of death (Item 23a) (Type, Print) 5. Baltimore Green 21201 egistrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 30, 2011 JESSE ROBERT CARR 4:40 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARFORD 1505 OLD PHILADELPHIA ROAD ABERDEEN 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Min. Country)
OHIO 89 Months Hours 8197/7922 Director 217-12-6227 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No MD BALTIMORE WHITE MARSH 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 10540 PHILADELPHIA ROAD USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2 Married 1 X Yes If Yes, Give within 72 hours after 2 🗌 No 1 Yes 2 No Specify: 1 and 2 should be filed within 72 hours aft if Health and Mental Hygiene. 3 🕅 Widowed 4 🗆 Divorced WWII Completed Year or Dates. WHITE traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MARTIN MARIETTA CRAFTSMAN 8TH GRADE $\mathbf{B}_{\mathbf{e}}$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ WALTER CARR VIOLA MACKEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY CARR/DAUGHTER 1505 OLD PHILADELPHIA RD. ABERDEEN, MD 21001 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MORELAND MEM. PARK 10/5/2011 HILLENDALE, MD Signature of Funeral Service Licensee MO1139 22. Name and Address of FacilitTHE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 No 1 Yes 2 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≙ has been signed by Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page certificate 1 Yes 2 No Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) DAUGHTER'S RESIDENCE
6 X Other (Specify) 2 No Hospital Other: 1 Yes 읻 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury To the Hospital or Attendii within 24 hours after death. To the Funeral Director. A completed filled in by the fu after death. Accident 1 Yes 2 No Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/2011 person who completed cause of death (Item 23a) (Type, Print) Yousef Waffar, MD 7501 Osler Dr. 21204 suite 103 Towson, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

3 2011

Baltimore, Maryland 21215-0036

68760

Box

P.0.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 09722/2011 de Wolf 6:30 Рм Bradford C. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Months Washington, DC 84 578-40-3184 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10a. State 10c. City, Town or Location with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Great Falls Virginia Fairfax 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 22066 1001 White Chimney Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? ģ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 - Widowed 4 - Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If item 27 is marked other than 's any injury or other traumatic event, the Megones. College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed Architect Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P Hazel Kearney Francis Colt de Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 White Chimney Court, Great Falls, Va. 22066 Gesine de Wolf/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Mofie y & King or other place) 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/26/2011 | Chantilly, Virginia Cremation Services Money & King Funeral Home, Inc 22. Name and Address of Facility Gary R.Downer 171 W. Maple Ave., Vienna, Virginia CCO 508 22180 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Atrial Flutter Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2^X No 3 ☐ Probably 4 ☐ Unknown of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Enpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 X Natural injury 5 Pending Division Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and til of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Atul Rohatgi MD 8600 Old Georgetown Road Bethesda, MD 20814 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 0 3 2011 Registrar

30pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) Month 09-27-2011 Physician/ 10:58aM Mary L. Doyle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Eldersburg 2010-D Rudy Serra Drive 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Hours 3/12/1933 Maryland 213-30-1882 78 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If from 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Framinar must he activity. 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🔀 No Eldersburg MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe Funeral USA 21784 2010-D Rudy Serra Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 1. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 12 O Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Sarah Elizabeth Pitzinger George Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2010-D Rudy Serra Drive, Eldersburg, Maryland 21784 Thomas M. Doyle / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 10/3/2011 Baltimore, Maryland Loudon Park Cemetery Donation 5 Other (Specify) Hubbard Funeral Home, Inc. ana re of Funeral Service Licensee 22. Name and Address of Facility 4107 WIlkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final cerebrovascular accident Physician/ day disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 mop Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 \square Nursing Home 2 1 No 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month/Day, Year) Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washing Kett 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Menth Jan 0013 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 63 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Month Day, 1 □ M 2 💢 F No Lintry) Jerse Director "natural", or items 23a or 28a-f show 10a. State 10b. County City, Town or Location 10d. Inside City Limits any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No ackensac 10f. Zip Code 10g. Citizen of What Country? by Funeral 760 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 \square Never Married 2 \square Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify lack 3 \ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) -astner Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Method of Disposition 20b. Place of Disposition (Name of Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause of the cause of t the death. Do not enter the Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami resulting in death) Last Due to (or as a consequence of) Physician/Medical e attending prover IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contribut not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🔲 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case reason within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, i Hospital or Attending Physician: Division of Vital 6. Place of Death (Check only one) Be 2 🗌 No 2 Yes 1 🔲 Inpatient 2 🕒 4 Nursing Home 5 Residence 6 Other (Specify R/Outpatient 3 🗆 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 2 🗌 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 31356 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCUS ENNIS DAMUEL : 33 A M 09-30-Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPICE GILCHRIST TOWSON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours Min 220-20-4131 Director 1 😿 M 2 🗆 F 82 Yrs. 02-21-1929 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director MD WINDSOR MILL 1 Yes 2 No 10f. Zip Code ō 10e. Street and Numbe 10g. Citizen of What Country? Funeral 23a 3405 IPPLE 21244 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. 0 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 'natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) BALTIMORE CITY the TREFIGHTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental P မ permit. Page 1 and 2 should be ENNIS AdA BOND WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health CARTER JONES (GRANDDAUghter 5506 AVE. BALTO, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State BATIMORE, MD 10/11/2011 SARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu of Funeral S 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCYS ervica Licensee LĐ YORK ROAD. BALTIMORE, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such 🛰 cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 1 ☐ Yes 2 ☐ Unknown Unknown been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No M Investigation

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The Certificate: within 24 hours after death. To the Funeral Director: After 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) 2gh Signature and title of certifier 29d. Date signed (Month, Day, Year) D0071 21204 Name and address of person who completed cause of death (Item 23a) (Type, Print) Month, Day, Year) State Registrar

DHMH 17 Rev 06-201

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			Registrar 1. Decedent's Name (First, Middle, Las	t)		Cert	incate of b	catii	:	2. Date of Deat			3. Time of Death	
	Physicia Medic		Mary Janet G	erkin					5	sep. 2	9, 20	11 Year	9:50 P M	
1	Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or					y of Death Carro	.11	
	Francis		Dove House 5. Social Security Number 6. Se	2x 7. Age (in yrs. last	birthdav)	Westm If Under 1 Year	If Under 24	4 Hrs.	3. Date of Birth		g. Birthp	lace (State or Foreign	
	Funeral Director			□ 373n-	64	Yrs.	Months Days	Hours	Min. N	$\overset{\text{(Month}}{\text{ov}} \overset{\text{Day}}{\text{-}} \overset{\text{Day}}{\text{-}} \overset{\text{-}}{\text{-}} \overset{\text{-}}} \overset{\text{-}}} \overset{\text{-}} \overset{\text{-}} \overset{\text{-}}} \text$	Year 946	West	Virginia	
	d it	L	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City. To	own or Loc	ation					1	0d. Inside City Limits	
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	h with	Funeral Director	2533 Cornstalk			Location	210		-0.40	f . V au N1a		.S.A		
020	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Standardarti If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	er in U.S.		as Decedent of Hi Yes, specify Cubar		n? (Speci Puerto Ri	ty Yes or No- can, etc.)		ice - Americ ack, White, e y: Wh		
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NG	2 shou th and t7 is m traum		19a. Informant's Name/Relationship (T) Donald V. Gerkin			19b. Mailing	Address (Street & Cornst	nd Number alk ⊺	or Rural I	Route Number, Finksl	City or Town,	State, Zip C	Code) 21048	
ນັ	f Healt f Healt item 2 other		20a. Method of Disposition		20h Plac	ce of Dispos	ition (Name of		Ds	ite	20c. Location			
2	Page nent o ant: If Iry or		1 X YBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Memo	verg verg	atory or other plac reen Gardei	ns ! :	10/4	/11	Fink	sburg	, MD	
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Г			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	plications that caused the cause on each one.	he death.	Do not ente	the mode of dying	g, such as ca	ardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death	
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	withi To #		29b. Signature and title of certifier	Kuty	7		29c. Licens	number	39	3	29d. Date sign	ned (Month,	Day, Year)	
			30. Name and address of person who	29251	DNE	北村	VE WE	SIMI	INS	PENC, V	W2	115	7	
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		or State Istrar				Cei	rtificate	e of D	eath				F	Reg. No				
Physician/ Madical Examine	1. D	ecedent's Name Cathie	dent's Name (First, Middle, Last) Lthie D. Haas										Date of Dea Month August 4	Day , 2011			3. Time of Death 1735 hrs	
*		Facility Name (if Baltimore W	ashington	Medica	I Center		4b. City, Town, or Location of Death Glen Burnie							,	c. County o	undel		
Funeral Director		ocial Security Nu	UNK	S. Sex											965		hplace (State or n untry) VA	
and show any nee.	10a M		Ob. County Anne	Aru		10c. City,	Town or I						10d. Inside City Limits 1 Yes 2 No					
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0036 within 72 hours after death with the Maryland giene. her than "natural", nr items 23a nr 28a-f she Medical Examiner must be notified at once omplefed by Funeral Director	Ever in U. X No		If Yes,	specify Cu	ban, N	Mexican, Pu s <i>pecify:</i>	erto Ri			White Specify:	w, etc. Wh	ite						
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ကို <u>ခ</u> န္တန္မရွိ ဂ		Father's Name (F		-			1			18			irst, Middle, MOS		Surname)	Surname)		
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s l and freal of Heal	1 [Donation 5	Cremation Other Spe	ecify:	Removal from Sta	te	crematory clan	or other p	Cre	n	8	/12	Date 2/201	1	Gle	n B	Town, State Surnie MD	
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Physician /Medical Examiner	Imn	failure. List only nediate Cause (F	one cause o	n each lir	ons that caused the. Metaxal					ing, su	ich as cardi	iac or n	espiratory ar	rest, sh	ock, or hea	art	Approximate Interval Between Onset and Death	
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box 68760, the death certificate be the attending physic ched for use as the bur Physician/Med		EMALE: Was decedent p past 12 months?		1 4	3c. If yes, outcom Live birth Pregnant at	,	2	Fetal o	death (S <i>pecify</i>)	3	Ectopic pre	egnand	y	23	3d. Date of Month		lay Year	
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F Vital Physician or this certi ral directo	2	examiner? 1 ✓ Yes 2		Hospi	tal: 1 Inpatier	nt 2 🗸	ER/Outp				ther ₄ Nu			_	ence 6	Other		
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Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as ledical Certification: To Be Completed by Physician	2 [3 [4 [Accident Suicide Homicide		igation not be	fd 8-4- 28e. Place of Inj (Specify)		ome, farm	4:40p , street, fa		_	-	2	8f. Location	(Street State)	2289	Fou	ral Route Number, City r Season Dr	
To the Hospital within 24 hours To the Funeral completely filled		July Crity		iner: On	To the best of my													
and manner stated. 29b Signature and title of certifier.															29d. Date signed (Month, Day, Year) August 5, 2011			
		Name and addre			Medical Exa			V. Baltir	nore St	reet.	Baltimor	e, Mi	21223					
State	e ³¹ .	Date filed (Month	, Day, Year)	4	32. Registrar					,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#18perFH, G920, 10/12/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menth 9:20р м 2 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis River Crescent Drive 9. Birthplace (State or Foreign Country) 6. Sex. 1 M 2 □ F If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 88 Hours 477-18-5330 08/25/1923 MN Director Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Annapolis must be notified MD Anne Arundel 1 Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21401 USA 2311 River Crescent Drive 12. Was Decedent Ever in U.S.
Armed Forces?
1A Yes 2 □ No
If Yes, Give 1942-70
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ral", or Iter Examiner Black, White, etc. Completed by 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5 + Elementary/Seconday (0-12) Captain U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Beatrice Spangler Wallace W. Hankins Sr. pengler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda H. Dukes Daughter 507 Tyree Lane Charlottesville VA 22901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Atlantic Crem 1 Burial 2X Cremation 3 Removal from State 9/26/2011 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Ser ThomasAllenPA 7090 Ridge Rd Hanover MD Fun Serv up ral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final DEVERE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it may be in the cause. Enter Underlying Cause (Disease or iinjury Certificate: To Be Completed by Physician/Medical Examine Due to lor as a consequence of the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funderal Director: After this certificate has been signed by the attending physicis completed filled in by the fundral director, page 2 should be detached for use as the burn completed filled in by the fundral director, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEART FAILURE Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown STENUSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 5 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 3 No Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 2 Accident injury 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) me and address of person who completed cause of death (Item 23a) (Type, Pfint) AINDA MAZIOIZ 11 State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 2311 River Crescent Drive Annapolis Anne Arundel 5. Social Security Number 9. Birthplace (State or Foreign Country) MD **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours 1 □ M 2√□ F 12th 297 Director 216-28-6826 924 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 🗆 Yes 2 🎽 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral יביייי אמון א filed within ובותאני 21 should be filed within ומון alth and Mental Hygiene. מוז 27 is marked other than "natural", or items 23 מוז 27 is marked other than "natural", or items 23 מוז 27 is marked other than "dedical Examiner must 2311 River Crescent Drive USA 21401 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate 1yr other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Lydia Ella Snook Arthur W. Giddings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1 and 2 s of Health 507 Tyree Lane Charlottesville VA 22901 Linda H. Dukes Daughter 20a. Method of Disposition
1 □ Burial 2 ※ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or o Atlantic Crem 9/28/11 Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv nome ThomasAllenPA 7090 Ridge Rd Hanover 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory at shock, or heart failure. List only one cause on each Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-f Physician/Medical Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 Probably 4 Noknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\simeg\) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phenitin 24 hours after death.

To the Funeral Director; After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending work? 2 🗆 No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date gigned (Month, Day, Year) completed cause of death (Item 23a) (Type Print)

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State Registrar

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Division of Vital

DHMH 17 Rev 7/2009

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	Physicia	n/			e, Last)								2. Date of Do		av '	Year	3. Time o	
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ı	Funeral Director		5. Social Security N 212-34-1521	L	6. Sex 1 □ M 2 XF	7. Age (i	In yrs. last birt 75	thday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bi	rth av, Year) O		9. Birth Cou	nplace (State ntry) MD	or Foreign
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1		1/1/	orces? 2 🛛 No ive		1	Vas Deced Yes, spec				cify Yes or No Rican, etc.)		Black,	14. Race - American Indian, Black, White, etc. Specify African-American		ican
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P.O.	that the	by Pi			ons contributing to	death but	not resulting	in the u	nderlying	cause giv	en in Part	1.	23e. Did	tobacco	use contrib	oute to	the cause of	death?
ds,	requires the been signed should be	ted t)YSPH	PLEGIA								1 2	Yes	2 □ No 3	B 🗆 Pr	obably 4	Unknown
of Vital Records,	aw relas be	Completed		JISFIIF									24a. Was	psy	pr	ior to c	opsy findings ompletion of	
Re	: The la												1 Yes	ormed?		ath?	2 🗆 No	
ita	ysician: The is certificate director, pag) Be	25. Was case referre examiner? 1 X Yes	ed to medical ≧No	Hospital:	1				1 - 1	ace of Dea							
of V	a Physer this eral di	e: To	27. Manner of Death	<u> </u>	28a, Date	of injury		Time of		Bc. Injury	4 LIN ∕at		me 5 Res 28d. Describe				<u>y)</u>	
	anding l sath. or. After he funer	ficat	1 X Natural 2 Accident	5 Pendir Investi	gation	nth, Day, \	rear) i	injury	М	work 1 🗌	? Yes 2] No						
Division	Hospital or Attending Physician: 24 hours at er death. Funeral Director, After this certificated filled in by the funeral director,	I Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could detern	ained 28e. Plac								or Rur	al Route Num	nber,			
	To the Hospital or Attendi within 24 hours all er death. To the Funeral Director. A completed filled in by the fu	Medical	(Check 2	! ∐ Medica⊌4	Physician: To the aminer: On the ba Nurse Practione	isis of exa	mination and/o	or invest	igation, in	my opinic	n, death o	ccurred at	the time, date	and place	ce, and due t	nd due to the cause(s) and manner stated.		
	To the vithing to the complex		29b. Signature and						290	. License	number				ate signed			
			•		W					JΨC	XOO4	<u> </u>			9/16	111		
>			30. Name and addre	AMIN Y	VANLANDI	NGH	AM M.I			os	LER	DRIV	/E TO₩	SON	I.MD	212	204	
	Stat	te	31. Date filed (Monti	h, Day, Year)	2 0 2011	Regi trar's	Signature	1.	bar	2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Physician/ Month 08 hnson 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bal If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign Country) 8. Date of Birth last birthday) 7. Age (In vrs. **Funeral** Months Days Director Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location Director 1 Yes 2 No MJ Hmore 10e. Street and Number 10g. Citizen of What Country? 21229 Funeral ark 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. D♥ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Be 18. Mother's Name (First, Midd ပ (Street and Number 20a. Method of Disposition 20b. Place of Disposition (Name of ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory 4 Donation 5 Other (Specify) ure of Funcial Service Licens 23a. Part 1. Enter ne disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (o as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that in the cause of the ca Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 1 🗌 Yes 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate has page 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After iniury Natural 5 Pending Division 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 301 5 205 address of person who completed cause of death (Item 23a) (Type, Print) AI

State Registrar 31. Date filed (Month, Day,

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 364 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav George Washington Knouse, Jr. Month M 9:15 A 2011 Medical October 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Dove House Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Days Hours Min. 1 🗶 M 2 🗆 F 216-22-9583 83 Director 1927 Usual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Finksburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21048 2880 Carrollton Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white "natural", Specify: 3 Divorced Year or Dates. WW II th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) salesperson beverage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Washington Knouse, Sr. Nancy May Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1 and 2 s of Health item 27 i Margaret E. Eline / wife 2880 Carollton Road Finksburg, Maryland 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hampstead Cemetery permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Hampstead, Maryland 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00723 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed andtran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) the 9 I Inknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 page ; performed? Yes 2 No certificate 2 🗌 No 1 Yes or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cente State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Mar	•	ertificate of			g. No 2011	31365
ì	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Juliann Kolanowsk			4h City Tourn O	r Location of Death	Septembe	er 19, 201	
)	Examin	er	4a. Facility Name (If not institution, give st 114 Martinique Ci			Berlin			Worces	
	Funeral Director		220-50-7783	M 2XIF	(In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/07/	Year) 9. Bir 1947 N	thplace (State or Foreign ountry) laryland
	land		Usual Residence of Decedent 10a, State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary a-f sh	ctor	MD Worcest	er	Berli	ı				1 □ Yes 2 No
	h with the 23a or 28 st by hot	al Dire	10e. Street and Number 114 Martinique Ci	r		10f. Zip Code 2181	1	10	Og. Citizen of What Co USA	ountry?
213-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Evanties i ust be incitified at once.	by Funeral Director		2. Was Decedent Ev Armed Forces? 1	ver in U.S. 1	3. Was Decedent of Hif Yes, specify Cuba 1 □ Yes 2 🔯 No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whit Specify: W	te, etc.
2	"natur	Completed	15. Decedent's Educa (Specify only highest grade	ition completed)) (G	ecedent's Usual Occup ive kind of work done e. DO NOT use retire	during most of workir		16b. Kind of Business	/Industry
7	withir iene. • than	шо	Elementary/Secondary (0-12)	College (1-4or 5+))	iano te ach	•		educatio	n
ğ	e filed al Hyg I other vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name			
yland	ould b Ment larked latic e	5 P	David Lewis Brigh					Lucille		
Mar	id 2 sh Ith and 27 is rr traur	8	19a. Informant's Name/Relationship (Typ Richard G. Kolanows)			ailing Address <i>(Street</i> L14 Martin	and Number or Rura ique Cir;	Berlin,	Maryland	21811
baltimore,	ages 1 ar int of Hea t; if item ; / or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place of Di cemetery,	sposition (Name of crematory or other plan	ce)	ate	20c. Location - City o	·Town, State
	bermit. Pa Departme mportani Iny injury		4 Donation 5 Other (Specify) 21. Signature Funeral Service License	Alphy	ctor	22. Name and Addre			my Board timore, M	21201
	402 4 6	-	23a. Part 1. Enter the disease, or complic	ations that caused t	the death. Do not					Approximate Interval Between
	Physician /Medical		shock, o'Neart failure. List only one Immediate Cause (Final disease or condition resulting in death)	neuro		e temor	of foncre	ase wit	h bets	Onset and Death
	Examiner		Convertible list conditions	Due to (or as a	consequence on.					
	ed sit	iner	Sequentially list conditions, if any, leading to infraediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a	consequence of):					
,	execut n and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
06/00,	rificate be executed ng physician and as the burial-transit	edical	d.							
×	ertifica ding ph		IF FEMALE:	c. If yes, outcome o	of pregnancy				and Date of d	alb and
O. BOX	ician: The law requires that the death cer certificate has been signed by the attendin rector, page 2 should be detached for use.	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	1 Live birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of d Month	Day Year
λ, T	gned by	by Ph	Part II. Other significant conditions conf	ributing to death but	t not resulting in th	e underlying cause gl	ven in Part I.			to the cause of death?
0.0	require									Probably 4 Unknown
ı Kecords,	The law ate has b	Completed						24a. Was a autops perfori	med? prior to death?	autopsy findings available completion of cause of ?
VItal	Physician: r this certific ral director,	Be C	25. Was case referred to medical examiner?	ospital:		Ott	26. Place of Death			
5	Physic ruthis (real direction)	5:	1 ☐ Yes 2 Ø No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	28a. Date of Injury		ne of 28c. Inju	iry at		ence 6 Other (Sp ow injury occurred	recify)
0	Attending ir death. ector: After by the funer	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,		ry Wo	rkí?]Yes 2□No		•	
UIVISION	Il or Attendi after death. I Director: A d in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm . (Specify)	, street, factory, office		28f. Location (S. City or Town	treet and Number or in, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of er: On the basis of and manner stat	examination and/	death occurred at the or investigation, in my	time, date and place, opinion, death occur	and due to the dred at the time, d	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	vithin To the	Me	29b. Signature and title of certifier	0	^		se number		29d. Date signed (Mo	nth, Day, Year)
			> Jelly R. L				066462	•	9-26-11	
			30. Name and address of person who con Jeffrey R Sheir	npleted cause of de	eath (Item 23a) (Ty	rpe, Print)	ed Berl	in mo	21811	
	Sta Registi		31. Date filed (Month, Day, Year) OCT 0 3 201	32/Registra	r's Signature —	faction k	- 4.11			
	gioti		901 0 0 201	· Marin	- 1. 1					

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amend 16a. per fb. g920.10-3-11 sm
State of Maryand / Department of Health and Mental Hygiene
amend #5 PER FH C920 10/07/2011 JH

Certificate of Death

Reg. 20 | | For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26 Day sept. 20 F June D. McCubbin 5:08 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Essex Baltimore 313 Oberle Avenue Social Security Nun**667** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-30-42 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 220-36-647 68 Director 1 □ M 2 🔀 MD 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Baltimore Essex MD 1 Yes 2 X No ö 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21221 USA 313 Oberle Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important; If item 27 is marked other tha any injury or other traumatic event, the Nonce. Unknown Giant Food retired Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surnama) te Idabelle Braithwaite ည Victor B. Warnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Oberle Avenue Essex, MD 21221 Robert A. McCubbin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 10/1/11 Baltimore, MD 4 Donation 5 Other (Specify) Sign tu e of Funer 22. Name and Address of Facility 300 Mace Ave Essex, MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between
Onset and Death
Months shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Metastati disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Dus to for as a consequence off Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🗙 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ၉ 1 🗀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Μ 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie D46118 30. Name a d address of person who completed cause of death (Item 23a) (Type, Print) OOPER 7141 Security 31. Date filed (Month, Day, Year) State 3 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O Physician/ ب 2:25 AM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 1K+ONMD If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) WV 1 M 2 □ F Months Hours 38 **Director** 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location notified at Director MD Cecil Chesapeake City 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 323 Lindsey Ave 21915 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. White "natural", or þ 1 Never Married 2 M Married 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If tem 27 is marked ofther than any injury or other traumatic event, the Me any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12yrs College (1-4 or 5+) Truck Driver Trucking Baltimore, Maryland ^{7. Father's Name (First, Middle, Last)} Ronald Mayle 18. Mother's Name (First, Middle, Maiden Surname) Doretta May Le 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 323 Lindsey Ave Chesapeake City MD 21915 Anne M. Mayle 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Atlantic Crem 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 9/27/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Refractory Septic Ph sician/ disease or condition Medical resulting in death) Due to (or as a con quence of): Examiner 4spiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify)☐ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Combined Division of Vital Records, No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation M 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yazan Sami Khalaf Haddadin 106 Bow Street Elkton MD 21921 31. Date filed (Month, Day, Year) State Registrar

Tyroue McQueen
11-07219 Please Type or F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

JAK OAK		1- For State Registrar		tate of Maryla		paπment d Certificate d		ina ivient		201 eg. No.	1 31368	
Physicia Medical Exami		1. Decedent's Nam Tyrone		• •		_			2. Date of Dea Month	th Day Year er 25, 2011	Time of Death 0400 hrs	
)				on, give street and nu	mber)		4b. City, Town,	or Location of		4c. County of De		
A.		3925 Dolfie	ld Avenue				Baltimore N/A y) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (Sta					
Funeral Director		5. Social Security N		6. Sex	7. Age (In yr	s. last birthday)		ear If Under	Min.	For	ei a n	
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' any		10a. State	10b. County		10c. C	City, Town or Loca	tion				10d. Inside City Limits	
Maryland 28a-f show d at once.	to	MD	N/Z	4		Bal	timore				1 Yes 2 No	
e Mary or 28a	Director	10e. Street and Nu 4029 Hi		рд			10f. Zip Code			Og. Citizen of What Co	ountry?	
with th		11. Marital Status	. 1 0011	12. Was Dec		n U.S. 13. W	2121 as Decedent of		n? (Specify Yes or No	U.S.A. 14. Race - Am	erican Indian, Black,	
death	Funeral	1 X Never Marri		1 Yes	2 X No	0			Puerto Rican, etc.)	White, etc.		
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0036 within iene. er tha	Completed	10th Gra				Ođđ	Jobs	_			Employed	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 23a-f sho traumatic event, the Medical Examiner must be notified at once.	BeC	17. Father's Name Tyrone							Name (First, Middle, Browder	Maiden Surname)		
212 ould be d Ment	일	19a. Informant's Na				19b. Mailir	g Address (Str			nber, City or Town, Sta	ite, Zip Code)	
MD nd 2 sh alth an alth an		Lela Br		(mother)		4029 b. Place of Dispo			, Baltim	ore, MD 2		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 she injury or other traumatic event, the Medical Examiner must be notified at once.	η			n 3 Removal fro	om State	crematory or o	ther place)					
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Per Per Peri		Diet	wh.	N. W. Jul	lear	ns 21	40 N.	Fulto	n Ave.,	Funeral H Baltimore	MD 21217	
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ed rsit	Examiner	(Disease or injury to events resulting in		Due to (or as a	consequence	e of):	-					
execu an and	Aedical	UNPENDED		d AMENDED							 	
760, cate be physical the buri		IF FEMALE: 23b. Was decedent	pregnant in the	23c. If yes, o		regnancy				23d. Date of delive	ery	
Box 6876; death certificate he attending phy defor use as the b	Physician/	past 12 months	?	LITTIVED	irth ant at time of	dooth -	etal death 3 ther (Specify)	3Ectopic p	pregnancy	Month	Day Year	
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P.O. es that the	à	Part II. Other signi	ricant condi	ions contributing to	death but no	ot resulting in the	underlying cause	e given in Part		obacco use contribute to a 2 ✓ No 3 Pr	o the cause of death?	
ords, F w requires to us been sign should be	Completed								24a. Was		autopsy findings available	
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tal Recinn: The certificate	မှ မှ	25. Was case refer	ed to medica				26.Pla		Check only one)	2 110 1	163 2 160	
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on of nding P. th. r: After		27. Manner of Death 1 Natural	n 5 Pend	28a. Date FOUND:		28b. Time of FOUND:	· · _	njury at Work? Yes 2 ✔ N	Subject she	now injury occurred t		
Division tal or Attendi rs after death. al Director: A led in by the fu	<u>E</u>	2 Accident 3 Suicide	Inve	stigation Sep 25,		0350 hrs t home, farm, stre			28f. Location (Rural Route Number, City	
Division of Vital Repipital or Attending Physician: The cours after death. For an Director: After this certificate filled in by the funeral director, page	Certification:	4 Homicide			Local Str	reet			or Town, S 3925 Dolfield	itate) Avenue, Baltimore,	MD	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b										e(s) and manner as st and place, and due to		
To t To t com	Medical	29b. Signature and		and manner st	ated.			nse number		29d. Date signed (N		
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Sta	t e	Ling Li, MD 31. Date filed (Mont		nt Medical Exan	niner 90 gistrar's Sign			altimore, M	D 21223			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 7,19b, per fb, 9920 10-14-11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month eptembe ne 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death tospice attimal DW If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Sex 7. Age (In yrs. last birthday) **Funeral** Days 216-68-409 Hours Director 1 🗆 M 2 🕟 55 Usual Residence of Decedent 28a-f shov 10a. State must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 10 Yes 2 □ No Honore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21206 4012 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married or. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No. Specify. "natural", Blac 3 Widowed 4 Divorced Completed Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ducation ertan Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname ည 19b. Mailing Address (Street and Number or Rural Boute Number 19a. Informant's Name/Relationship (Type City or Town, State, Zip Code) 214 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 6202 Ster th more 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) prematory or other place) Signature of Funeral Service Licensee 22. Name and Address of Facility HIMO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cholanero Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). law requires that the death certificate be executed and -trar that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Box 68760 attending IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a □ Pregna... □ Unknown 9 P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been signated by page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No or Attending Physician: The 2 🗌 No certificate 1 Yes **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Wother (Specify) NOS DILCE this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending М 24 hours after death Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical within 24 hou

To the Fune

completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated d title of certifier 29b. Signature a 58303 Mun address of person who completed cause of death (Item 23a) (Type, Print) IV. Charles SP MIKES NNO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 3 2011 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Joanne E. O'Connell 28, p^{M} Sept. 2011 7:09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 27A Oak Grove Drive Middle River 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 28, 1955 6. Sex 7. Age (In yrs. last birthday) 56 Yrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2**X** 220-68-4778 Connecticut Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be mortified at Funeral Director MD Baltimore Middle River 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21220 27A Oak Grove Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2**X**XX0 Specify: White Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) tould be filed within 7. Mental Hygiene. 2121 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Smith Joseph Samonek ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacob O'Connell/ 409 Edmonds Way Baltimore, MD. 21221 permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other: once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill 10/01/11 |Baltimore, MD 4 ☐ Dopation 5 ☐ Other (Specify) Balto. ML 21221 21. Sign tunneral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Connelly FUneral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Arrenosdero **Physician** andiqua sculot d disease or condition resulting in death) /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performe certificate 2 No 1 ☐Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No neral Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person oleted cause of death (Item 3a) (Type, Print) Ivimbl 2. Registrar's State

Registrar

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Division of Vital Records, P.O. Box 68760,

Day 2011 8:55 am 4c. County of Death Baltimore 9. Birthplace (State or Foreign F'EB'. 5 , T921 Virginia 10d. Inside City Limits 1 X Yes 2 ☐ No 10g. Citizen of What Country? USA 14. Race - American Indian. Black, White, etc White Specify: 16b. Kind of Business/Industry Balto. Co. 18. Mother's Name (First, Middle, Maiden Surname)

Pheobe O'Quinn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 941 Quantril Way Baltimore, MD. 21205 20c. Location - City or Town, State Baltimore, MD Connelly Funeral Mace Avenue Balto. Connelly Funeral Mome of Essex 21221 Interval Between Onset and Death recke 23d. Date of delivery Day Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Yes 2 A 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01 N chewles (att 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Ame	nd	#25, per ME g919	Type or Print in	Black Ir	ndelible In	k. Ensure	All Copies	Are Leg	gible.	
		State Registrar			tificate of L			Reg. No 2 0	11	31372
Physicia Medic		1. Decedent's Name (First, Middle, Las	L·	Pap	osch		2. Date of Dea Month September	Day	Year 2011	3. Time of Death
Examir		4a. Facility Named not institution, give The Johns Hoph			4b. City, Town, o	r Location of Death	h	4c. County		
Funeral Director		5 Social Security Number 6. Se		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthpl Countr	lace (State or Foreign
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Married 2 🔀 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1. ■ Wes 2 □ No If Yes, Give Year or Dates. Nav		Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		e - America ck, White, e Whi	tc.
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Baltimore, Maryland 21215-0036 sermit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiener. In filem 27 is marked other than "natural", only injury or other traumatic event, the Medical Examples.		20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Ch		sition (Name of natory or other place Cremat	ory 9/2	Date 2/2011	20c. Location - Beltsv	-	
Balti permit. Departr Importa any inji		21. Signature of Funeral Service Licens	*Porota Mars	hall 22.	Maryla PO BOX	ss of Facility and Cren 1413,	mation :	Servic	es D 21	203
Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	- 1	r the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
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68760 certificate be reding physic	Medic	IF FEMALE:	d			CERTIFICATION	APPING		_	
ords, P.O. Box 68760 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3 🗌	Ectopic pregnand Other (specify)			23d. Da	te of deliver	ry Day Year
S, P.O.S.		Part II. Other significant conditions co	ntributing to death but not re	esulting in the un	nderlying cause giv	en in Part I.				e cause of death?
cords aw requir	Completed by						24a. Was a	n 24b. \	Were autops	sy findings available
al Re in The is ifficate h or, page		25. Was case referred to medical			26 Pla	ace of Death (Chec	perform 1 Tyes	med?	death?	_
f Vital Physician: this certific	To Be	examiner? 1 X Yes 2	lospital:		3 🗆 DOA Othe	er: 4 Nursing H	ome 5 Reside	ence 6 🗌 Othe	er (Specify)	
ivision of Vital Reco to Attending Physician: The law after death. Director After this certificate has in by the funeral director, page 2	Certificate:	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗌		28d. Describe ha	ow injury occurre	ed	
Division of Vital Records, the Hospital or Attending Physician: The law requires fin 24 hours after death. The Funeral Director: After this certificate has been sign mpleted filled in by the funeral director, page 2 should be	al Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Speci	fy)		13	28f, Location (St. City or Town	n, State)		
Dir To the Hospital or within 24 hours at To the Funeral D	Medical	(Check 2 \(\subseteq Medical Examin	cian: To the best of my know er: On the basis of examination Practioner: To the best of r	on and/or investic	gation, in my opinio	on death occurred a	at the time date an	d place and due	to the caus	se(s) and manner stated
To t vith com		29b. Signature and title of certifier			29c. License		1	9d. Date signed	10	ay, Year)
34		30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Type, Pri	int)	Baltima	se Manila	od 21	1287	
State Registra	_	31. Date filed (Month, Day, Year)	32. Registar's Sign.	ature A.	parker	241111111	- CI YIA	<i>4</i> 10	I	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31373 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ JOHN E. PAZDERNIK 09:35 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL N/A BALTIMORE CITY 5. Social Security Number 6. Sex 1 X M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/15/1943 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. MARYLAND Director 67 214-42-2091 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits MD BALTIMORE PARKVILLE 1 Yes 2 XNo 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 23a 9003 SATYR HILL ROAD PAZDERNIK 21234 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) YEARS 4 SALES MANAGER DURRETT SHEPARD STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ pe JOHN PAZDERNIK, JR. SARAH RYAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 STACEY ROCK/DAUGHTER 8739 LACKAWANNA AVENUE BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of H 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 9/29/2011 CATONSVILLE, MD Signature of Funeral Salvice Licentee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. M01139 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ INTRAPARENCHYMAL BRAIN HEMCRRHAGE 9-10 day Medical Examiner MELLITUS, HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical law requires that the death certificate be P.O. Box 68760 the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 1 Yes 2 9 Unknown 2 🗆 No should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Theambasis 24a. Was an autopsy performed? Yes 2 No 2 No Division of Vital 25. Was case eferred to medical Be 26. Place of Death (Check only one) examiner? 2 al No Other: No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, Homicide City or Town. State) within 24 hours a To the Funeral L Medical 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Numer Practioner: To the best of my his words, shall commit at the firm, defeated becomes a date to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES DOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BLVD, BALTIMORE AMIT BANJA 31. Date filed (Month, Day, Year, State Registrar

0/0847

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Deced nt's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** /Medical acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nesis DME 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number (In yrs. last birthday) **Funeral** Months 1**⊠**M 2□ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-4 shov any injury or other traumatic event, the New Isoal Examiling must be notified at 1 Tes 2 □ No Director Timore 10g. Citizen of What Country? Street and Number by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CUKHOWN (unknown ပ 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b, Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe this certificate 1 ☐ Yes 2 ☐ No 1 □ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred medical examiner? Be 26. Place eath (Check only one) Hospital: 1 Yes 2√No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2630 5. se of death (Item 23a) (Type, Print) 30. Name and address of person who completed c

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 500 A M Morth Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 735 Essex Baltimore Avenue Baltimore Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2x Months Days Hours Min. 7/12/50/1/2 P Director Kentucky 401-28-9634 90 Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified · 28a-f MD 1 Yes 2 X No Baltimore Essex 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 1509 Lanflair Rd Apt. 21221 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify White Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Cement Union 10th Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clara Pike Dewy Epply 19a. Informant's Name/Relationship (Type, Print) (niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 735 Essex Ave. Baltimore, MD 21221 <u>Catherine R. Smith</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Bayview Crematory 10/1/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave Essex, Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do no, enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ RIMEV disease or condition) Medical resulting in death) Due to (or as a con quen e of): **Examiner** Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Dise to for as a consciousings on and I-transit Exami resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Medical certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No **Hospital or Attending Physician:** The law requires that the death 24 hours after death. Month Year Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has I
in by the funeral director, page 2 s performed. Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 \square Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No М Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and 29c. License number

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar 31376 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Juanita Pusloskie 2:18 AM Medical 2011 Sept 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 11129 Bird River Grove Road White Marsh Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Min. 1 □ M 2 □ F Hours Director 1944 Virginia show with the Maryland notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Tyes 2 No MD Baltimore White Marsh ems 23a or r must be n 10e. Street and Number 10g. Citizen of What Country? Funeral 11129 Bird River Grove Road 21162 U.S.A. items within 72 hours after death ral Hygiene. 3d other than "natural", or items event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic John Harold Boughers Juanita O'Dell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WhiteMarsh, MD Linda Baker / Daughter 11129 Bird River Grove 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Shipley Cemetery 10/02/2011 Bristol f Funeral Service Dicense. 21. Si atu 22. Name and Address of Facility 300 Mace Ave. Balto MD. Connelly Funeral Home of Essex 21221 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Dea Physician 100 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Other to for as a consequence of; cause. Enter Underlying Cause (Disease or injury Exami burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death Day Year the Unknown P.O. þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed been significant 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 \square Pending injury work? s after death.

I Director: Af
ed in by the fu Accident
Suicide Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) SQUALE DRIVE

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

BALTIMORE, MDZIZS 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nicholas J. Passarella 09728/2011 1:50p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Spindrift Way Anne Arundel Annapolis . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Hours 219-03-6728 90 0671471921 **Director** MD Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 Spindrift Way 21403 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give 1943-45 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: SpecifiWhite Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Jeweler Jewelry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angelo Passarella Lebra Cimagli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Spindrift Way Annapolis MD 21403 Nora Rita Passerella wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State Arlington Nat 12/20/11 Arlington VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph sician/ erdiac Medical Examiner Coronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and I for use as the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Colon Cancer 1 ☐ Yes 2 ⊡ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case | ferred to pre ical after death.

Director: After this certificate 2 🗌 No 1 Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. To Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 1 Yes 1 Inpatient 2 TER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10-03-201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 128 LUBRANO DRIVE

32. Registrar's Si

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State of Maryland / Department of Health and Mental Hygiene

ROBORT A STRUCK CONTROL AND A	Physician (Model) Figure 10 (1997) Figure 10 (1	For State Registrar	Maryland		cate of	Death		Reg. No.			
Security of Death Secu	The control of the co	Physician	Month Day Year									3. Time of Dea	
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doc 6 26 34 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29c. License number 29d. Date signed (Month, Day, Year 29d. Date signed (Month, Day, Year 29d. Date signed (Month, Day, Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATEEN AWAN 1976 HICKNAY RIAGE AD CELUMBIA MID 21.44	e Hospita 24 hours e Funera letely fille		(Check only 2 Medical Examiner: On the base	asis of examinat ner stated.	tion and/or inves	tigation, in my	opinion, death occ	curred at the time	e, date and	place, and d	ue to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATEEN AWAN 10796 HICKORY RIAGE RD COLUMBIA MD 21.44	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date	signed (Mo	nth, Day, Year)	
1 1 1/1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	MATEEN AWAN 10796 HICKORY RIALE RD COLUMBIA MID 21.44	•			se of death (Item	23a) (Type, Pri		0662634		DEP	27,	20//	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 6:39 A M 2 Date of Death pollano Physician/ Month Dav Paulette Jepk mber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A805 N. Collington Ave. Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 218-42-9242 **Director** 1 □ M 2 🔀 F 10/25/1946 Maryland 64 Usual Residence of Decedent show 10b. County notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 XYes 2 No N/A Baltimore MD ms 23a or must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21205 805 N. Collington Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 😾 No Specify: Specify: "natural" Completed 3 Divorced Black Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Johns Hopkins (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

27 is marked other than traumatic event, the Me 12th Grade College (1-4 or 5+) Claims Adjuster University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Julia Leatrice Walker James Paul Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 N. Collington Ave., Baltimore, MD 21205 it of Health a Carol Coates (daughter) other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Burial 2x Cremation 3 ☐ Removal from State ō Department of Important: If any injury or once. on-site Crematory Baltimore, MD 3 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Joseph Adms of Brown Jr. 2140 N. Fulton Ave., Funeral Home PA, Baltimore, MD 21217 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final un ancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death signed by the a 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician; The law 124 hours after death.
Funeral Director: After this certificate has b autopsy death? 1 ☐ Yes 2 ☐ No Yes filled in by the funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending iniury 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral I 🖳 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Williagrapalul as 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore MD 21209 N.S. Kajapalese M.D. 2835 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of W	iai yiaira /		tificate of				Reg. N	2011	3 380	
	Physicia	n/	1. Decedent's Name (First, Middle	le, Last)		_		_		2. Date of De		Day Year	3. Time of Death	
	Medic	al	Mary Rebecc							Month 10/			6:45 A ^M	
	Examin	er	4a. Facility Name (if not institution Ridge Over1	-			4b. City, Town, or Location of Death Westminster					4c. County of Death Carrol1		
	Funeral		5. Social Security Number	6. Sex 7. Ac	ge (In yrs. last bir	thday)	If Under 1 Year	If Unde	r 24 Hrs.	8. Date of Bir	th Voor	9. Bir	thplace (State or Foreign	
	Director		218-64-6953	1 □ M 2 🖾 F	92	Yrs.	Months Days	Hours	IVIII I.	27107	191	9 60	untry) MD	
	ind show at	٦	Usual Residence of Decedent 10a. State 10b. County	/	10c. City, Tow	n or Lo	cation						10d. Inside City Limits	
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Maryland	2 shouth and the and the strain traum.		19a. Informant's Name/Relations		- 1		ng Address (Street Dogwood				-		o Code)	
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mo	Page nent o		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (natory or other pla UMC Ceme		10/5	/2011	Mt	. Airy,	MD	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur of Funeral Service	Licensee		21	Name and Addr	રુપ ર્શ હૈસાં	lit T une	ral Hon			ory, P.A.	
1212 W. Old Liberty Rd., V. 29a. Part/I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespace, or heart failure. List only one cause on each line.											irreru, i	Approximate Interval Between		
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-	Medical Examiner		resulting in death)	Due to (or as	a consequence	of):							Years	
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89	ath certifi attending I for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	h 3 [☐ Ectopic pregnan	ICV			ļ	23d. Date of de	livery	
Box 68	t the death by the att	Physician/I	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		at time of death		Other (specify)					Month	Day Year	
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Division	l or Attenc after death Director /	Certificate:	3 Suicide 6 Could 4 Homicide determ	28e. Place of In	ury - At home, fa c. (Specify)	arm, str	eet, factory, office		1	28f. Location (3 City or Tov			ral Route Number,	
Ō	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifyin	g Physician: To the best o	f my knowledge,	death	occured at the tim	e, date and	d place, and	d due to the ca	use(s)	and manner as sta	ated.	
	he Ho lin 24 ł he Ful pleted	Medical	(Check 2 Medical	Examiner: On the basis of eg Nurse Practioner: To the	examination and/	or inves	tigation, in my opin	ion, death	occurred at	the time, date a	and plac	ce, and due to the	cause(s) and manner stated.	
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)		20 Name of the Contract of the	who completed cause of	hysiet ar			10147			10	0/3/11		
)			30. Name and address of person	D.O. IS	12 S. N	lain	St. M	t. Air	1, M	0 2177	H			
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	ack	St., M		•					

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

3 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011

31382

For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 29 2011 1:04 P M Talitha Ann Roop Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Hospice Dove House Westminster Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🕱 F Days Aug. 26, 1929 Months Hours Maryland Director 218-24-7632 82 Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Carroll New Windsor 1 Yes 2 X No 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 4114 Hawks Hill Rd. 21776 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2X Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nora Baker Harvey Roser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rauland H. Roop - husband 4114 Hawks Hill Rd., New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗌 Cremation 3 🗋 Removal from State Pipe Creek Cemetery 10/3/2011 Linwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home Signature of Fureral Service Licens atharine 310 Church St., New Windsor, MD 21776 ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed phods 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? funeral director, 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2. 1 No ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of mylknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature a no completed cause of death (Item 23a) (Type, Print)
ex M.D. 555 S. Center St Westminster MD 21157 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 207PM September 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number last birthday **Funeral** 251-90-6915 Months Days **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No by Funeral Director towar Olumbia 10g. Citizen of What Country? 10e. Street and Nun 10f. Zip-Code 52 21045 Coor Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life_DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Department of Health and Mental Hygiene, Important: If Item 27 is marked other than any injury or other frammatic College (1-4 or 5+))alesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be ဂ္ awrenc or Rural Route Number, City or Town, Informant's Name/Felationship (Type. Print) 19b. Mailing Address (Street and Number 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 [Other (Specify) Greene Funeral Services Service Licensee 21. Signature of Funera MIC 23a. Part 1. Enter the diseas shock, or heart tailure. Approximate Interval Between sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or are. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Myocardia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No completely filled in by the funeral director, page 2 should be detached P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 \sum Yes 2 Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 □ No 26. Place of Death (Check only one) Other 2 ER/Outpatient 1
Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 3 🗌 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After the formula of the f 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ρ RES-00 September 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 ex 31. Date filed (Month, Day, Year) 2. Registrar's Signature State OCT 0 3 2011

DHMH 17 Rev 1/2001

Registrar

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	_		State Registrar 1. Decedent's Name (First, Middle, Last)	C	ertificate of Death	2. Date of Deat	Reg. No. 2			
Pi	hysicia		Joseph G. Seitz Jr.			Month 9	Day Year 2011	3. Time of Death 1854 M		
E	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of D		4c. County of Death	•		
		10	RNINSULA REGIONAL MEDICAL 5. Social Security Number 6. Sex 7. Age	Center	A LISBA	Hrs. 8. Date of Birth	HICIM			
	uneral rector		218-42-2337 1 XM 2 \[\subseteq F \]	(In yrs. last birthday		Min. (Month, Day, March1	Year) 1945 P	nplace (State or Foreign ntry) A		
ъ	show d at		Usual Residence of Decedent	10c. City, Town or	location		,	10d. Inside City Limits		
arylan	a-f sh ified a	ecto	MD Baltimore	· ·	Essex			1 🗆 Yes 2🏝 No		
the M	a or 26 se not	۱	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Cou	untry?		
be filed within 72 hours after death with the Maryland ental Hygiene.	ns 23; must l	Funeral Director	111 Mace Avenue		21221	10 11 N	USA			
er dea	or iter niner	by Fu	11. Marital Status 1 □ Never Married 2 🔀 Married 12. Was Decedent EV Armed Forces? 1 🛣 Yes 2 □ N		 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, President 		14. Race - Amer Black, White	, etc.		
urs afte	ural", Il Exar	ted b	1 ☐ Never Married 2 🔀 Married 1 🛣 Yes 2 ☐ N If Yes, Give Year or Dates.		1 ☐ Yes 2 XNo Specify:		Specify: Whi	.te 		
72 hoi	n "nat fedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Gir	cedent's Usual Occupation re kind of work done during most of DO NOT use retired)	working	16b. Kind of Business/I	ndustry		
within giene.	er tha		Elementary/Secondary (0-12) College (1-4 or 5+ 1 2	+) """	Mechanic		Vending	Machine		
e filed ntal Hy	event	To Be	17. Father's Name (First, Middle, Last)			Name (First, Middle, No. 1971) Sy Baldwi				
ould b	mark		Joseph Seitz 19a. Informant's Name/Relationship (Type, Print)	19h Ms	illing Address (Street and Number of			Code)		
d 2 sh alth ar	n 27 is er trau		Lynda Seitz/ Wife	111	Mace Avenue,	Essex, M	D. 21221			
permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State	20b. Place of Dis	position (Name of rematory or other place) wn Cemetery 1(Date	20c. Location - City or Baltimore			
nit. Pa artmer	ortant injury e.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee							
perr	any		MUDUATA BOU	2	22. Name and Address of Facility (Connelly Fune)	ral Home	of Essex	21221		
			23a. Part 1. Enter the disease, or complications that caused a shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death		
1	ician/ edical		Immediate Cause (Final disease or condition resulting in death) a. SEVER	E TRIP	LE VESSEL CO	RONARY ART	3243210 YAS	Onsoi and Beath		
Exa	miner				OCARIDAL INFA					
D	sit	Examiner	if any, leading to immediate Due to (or as a cause, Enter Underlying	consequence of):						
xecute	an and rial-transit	Еха	that initiated events resulting in death) Last C. Due to (or as a	consequence of):	5 1					
or Attending Physician: The law requires that the death certificate be executed after death.	nysicia he buri	dical	Ld. HYPO:	XIC EN	CEPHALOPATHY					
ertifica	attending pl	/Me	IF FEMALE: 23c. If yes, outcome o	of pregnancy			20d Data of dall			
eath c	atten d for u	iciar	in the past 12 months? 1 Live Birth 2	Fetal death	B		23d. Date of deli Month	Day Year		
t the d	by the stache	Phys	9 Unknown 9 Unknown	hand see the see to the	and of the second size Death					
es tha	been signed by the s	Completed by Physician/Me	Part II. Other significant conditions contributing to death but ACUTE RENAL FAILU		e underlying cause given in Part i.		oacco use contribute to es 2 No 3 Pr			
redui	shoul	lete				24a. Was ar	24b. Were aut	opsy findings available		
he law	ate has	omo				— autops perform 1 ☐ Yes	ned? death?	ompletion of cause of		
cian:	ertific	Be	25. Was case referred to medical examiner?		26. Place of Death (
Physic	gig	은	1 Yes 2 No Hospital: 1 Inpatier 27. Manner of Death 28a. Date of injury	nt 2 ER/Outpar			ence 6 Other (Speci w injury occurred	fy)		
nding ath.	r: After ie fune	icate	1 X Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation				w injury occurred			
r Atte	irector n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.		street, factory, office	28f, Location (St. City or Town	reet and Number or Rur , State)	al Route Number,		
To the Hospital or Attending Pl within 24 hours after death.	filled i		29a. Certifier 1 Certifying Physician: To the best of m	ny knowledge des	h occurred at the time, date, and old			ated.		
n 24 hr	ne Fun pletely	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the	amination and/or inv	estigation, in my opinion, death occur	rred at the time, date an	d place, and due to the o	ause(s) and manner stated		
To th	To the		29b. Signature and title of certifier		29c. License number		9d. Date signed (Month	, Day, Year)		
4	(cal		Helat	ath (the cook of	D4250		4/29/11			
	00		30. Name and address of person who completed cause of der	ath (Item 23a) (Type	exten there D	sive Delet	my, mp 21	801		
	Stat	te	31. Date filed (Month, Day, Year)	's Signature	. V.I		0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 7 N 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1/2011 Physician/ 7:30 A M Lillian M. Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Sykesville Brinton Woods Nursing & Rehab Center If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Country) MD Months Days Hours Min. (Manth Day Year) 91 **Director** 231-14-7437 Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Westminster MDCarrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21157 4510 Salem Bottom Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 No Specify: Yes, Give White "natural" Completed 3XXWidowed 4 □ Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natu ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Her Home 10 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Mary Compton William Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4510 Salem Bottom Rd., Westminster, MD 21157 Yvonne Baker/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Sykesville, MD 4 Denation 5 Other (Specify) Lake View Mem. Park 10/5/2011 21. Signa ure o Funeral Service Ligensee ²²Burrier Que eilly Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Inter the disease, or complications that caus within leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Approximate n each line hock or heart failure. List only one cause, Interval Between Onset and Death diate Cause (Final ELANDRATIVE MONTA MARK Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for as a consequence of: if any, loading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) sate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗹 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manur r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the besto of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practions. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certified 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

Registrar's Signature

BUSINESS CENTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

10/3

ETSTORSZEWN

4a. Facility Name (If not institution, give street and number) Examiner Talbot Easton 8494 Aveley Farm Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/07/1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Hours 1 X M 2 □ F Days Director 215-28-6358 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a State 10b. County Easton Talbot Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21601 8494 Aveley Farm Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amped Forces? 1 Myes 2 □ No 1953 − If Yes, Give Year or Dates: 1956 Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) builder construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hattie Pearl Dickinson Frank Thomasson, Sr. ဥ 19a Informant's Name/Relationship (Type, Print)
Sherrylyn Diane Thomasson/Wife
Shirley Thomasson wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8494 Aveley Farm Rd; Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Se Ronald Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final disease or condition resulting in death) **Physician** logen /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an has 9.2 s autopsy performed? Yes 2 No page certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗌 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

and manner stated.

BRESE

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per Ana BD G920 10/13/2011 IH State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

Reg. No.

T₂

2011

4c. County of Death

9:15

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Month

eors

Year

Day

Were autopsy findings available prior to completion of cause of death?

2 No

1 ☐Yes

29d. Date signed (Month, Day, Year)

ANNAPOLI

1 □Yes 2 No

Maryland

white

2. Date of Death

September

Registrar DHMH 17 Rev 1/2001

State

(Check only one)

31. Date filed (Month

29b. Signature and title of certiff

1 - State Registrar

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

James Willard Thomasson

29c. License number

D0023060

820 Bestyste Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O Physician/ 1920 obert Trent Medical $\overset{\text{County of Death}}{N/A}$ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bultimore University of Maryland Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** 1 😾 M 2 🗆 F Hours 0997676956 Vfrginia 219-66-9986 55 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Examiner must be notified X□ Yes 2 □ No N/A Baltimore MD ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21217 U.S.A. 2601 Madison Ave. Apt 1001 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced "natural", or þ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Marriott Hotel Server 11th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Hattie Sue Trent Robert English 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD21217 2601 Madison Ave. Apt 1001, Baltimore, James Grossman(friend) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Zion Cemetery 10/04/11 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee JOSEPHADES OF BROWN Jr. Funeral Home PA MD 21217 2140 N. Fulton Ave., Baltimore, 23a Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Close (Final Approximate Onset and Death Physician/ disease or condition resulting in death) Regula tation Aprtic Valve Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Gortic Dissection Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 X No Yes 2 🗆 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tyes ဂ္ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) SECERTIFYING Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 7/2009

S. Greene St. Baltimore MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 24a per med cert G920 10/3/11 dk
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28 28 2011 8:12 AΜ August Howard Joseph Watson Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 544 E. Clement Street Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth. 6. Sex 1 X M 2 □ F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Oct 13, Hours Min. Days Maryland Yrs. Director 63 217-46-4973 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 1X Yes 2 ☐ No **Baltimore** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be Funeral USA 21230 544 E. Clement Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces2 1 Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married white Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) marina security 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shirley Martha Wallner မ Jesse Howard Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State Zip Code) 2926 Rayshire Rd; Baltimore, MD 21230 Howard Watson Jr - son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □XDonation 5 □ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Service Sensea 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MCMLAS Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Due to (or as a consequence of Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine ears attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ cate has been signed by the atte page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Dres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ulmonay 24a. Was an autopsy performed 1 Yes 2 1 No Yes 2 XNo 24 hours after death.
Funeral Director: After this certificeted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\to\) Nursing Home 5 \(\text{Nesidence}\) Residence 6 \(\to\) Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural injury 5 Pending Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number eman 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10. N. Gicene Street Ballimore HEMANI, M.D. 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2011 Registrar

DHMH 17 Rev 7/2009

Howard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 31389 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2, 2011 2:52 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Carroll Westminster 1000 Weller Circle, Apt 324 . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Months Days NOVITA Pay, Year 924 Hours Min Westwirginia 236-36-0163 86 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westminster 28a-f Carroll Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 1000 Weller Circle, Apt 324 USA should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian "natural", or ite Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene.
27 is marked other than "
r traumatic event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Lab Technician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Grover Allen India Light 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 860 Jessica Lee Drive, Westminster, MD 21157 Karen E. Pumphrey, niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🕱 Removal from State 9/14/2011 Hilldale, WV 4 Donation 5 Other (Specify) Pisqah Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Myers—Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2. No Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? Hospital or Attending Physician: The 1 Yes 2 No : After this certifica e funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ပ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No Accident Investigation Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) 5. Center of Wes

State Registrar

Box 68760

P.O. I

Records,

Division of Vital

DHMH 17 Rev 7/2009

31. Date filed (/

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 10,2011 Oscar William Armwood 8:15 Am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Worcester Berlin Nursing & Rehabilitation Center Berlin Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Funeral . Age (In yrs. last birthday, 8. Date of Birth Days Months 1 X M 2 1 July 9, 1937 Hours Min. Mary I and **Director** 214-34-8308 74 Usual Residence of Decedent 23a or 28a-f shov 10a, State 10b. County nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland bartment of Health and Mental Hygiene. bortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 X No MD Worcester Berlin 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9715 Healthway Drive 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 XWidowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10th College (1-4 or 5+) The City Of New York Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Herbert Armwood, Sr. Lola Holden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randolph Waters / Son 1258 Welson Road - Orlando, Florida 32837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. James UMC Cemetery Sept. 15, 2011 Westover, MD 21. Signature of Funeral Service Licensee Salisbury, Maryland 22. Name and Address of Facility Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications to t caused the deal shock, or heart failure. List only one cause on each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition par Medical resulting in death) a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing indepth). Examiner Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
• Funeral Director, After this certificate has been signed by the attending physicia Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 1 ☐ Yes 2 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate has been signed director, page 2 should be dei 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 N ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 🎇 No Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 2 Accident 3 Suicide 5 Pending work? Investigation 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 29a. Certifier XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying thurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one occurred at the time, date and place, and due to the 29b. Signature and title of ea 29c. License number 29d. Date signed (Month, Day, Year) September 12, 2011

State Registrar

Oscar

Armwood,

9715 Healthway Dr,

Berlin, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. egistrar's Signatu

Robins,

William H.
31. Date filed (Month, Day, Year)
SEP 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per fb g920 10-19-11 byted Montel Hydione

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prod.	Physicia Medio		Leonard B. Bonsal					Month 09	13 0	20/1 2207 M		
	Examin		4a. Facility Name (if not institution, give street and number) Peninsula Regional Medic		ner		r Location of Death		4c. County of Death Wicomico			
	Funeral			ge (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)		
	Director	Usual Residence of Decedent								Maryland		
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	or 28a- notifi	Director	10e, Street and Number	1 1	THECS	10f. Zip Code			10g. Citizen of Wh	1 🔀 Yes 2 □ No		
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9036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show fedical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes 1 Yes 1 Yes 1 Fyes, Give Year or Dates.	? 196	6- "	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🔀 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, White, etc. White		
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	ge 1 and 2 should be filed within 72 hour It of Health and Mental Hyglene. If item 27 is marked other than "natun or other traumatic event, the Medical		19a. Informant's Name/Relationship (Type, Print) Margaret W. BonsalMoth	er	19b. Mailin 1243.	g Address (Street a Loretta	and Number or Rur a Rd., Ap	al Route Number, t. 5 Pr	City or Town, Sta	te, Zip Code) Anne, Md 21853		
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i	Cy, Md.										
Balti	permit. Departr Imports any injl		21. Signature of Funeral Service Licensee	M00295		Name and Address 11673 Son	ss of Facility H		neral Ho cess Ann			
			23a. Pap 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Immediate Cause (Final	ed the death ne.	. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death		
5.00	Ph_sician/ Medical		disease or condition resulting in death) a. Due to (or as	s a conseque	70 E	Suplay	stal C	<i>A</i>				
30.	Examiner	<u>_</u>	Sequentially list conditions, b. 54	Sis								
	led nsit	Examiner	rating, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a conseque	ence of):							
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Box 687	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	2 Fetal at time of de	death 3	Ectopic pregnand Other (specify)	ey		23d. Date Mont	of delivery h Day Year		
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rds,	requires that been signed k should be det	ted						1 🗆 Yı		Probably 4 🕰 Unknown		
Division of Vital Records, P.O.	s ician: The law r certificate has b lirector, page 2 sk	Completed						24a. Was a autops perfori 1 \(\sum \) Yes	med? pri	ere autopsy findings available for to completion of cause of ath?		
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	al Certificate:		jury - At hor tc. <i>(Specify)</i>		et, factory, office		28f. Location (St City or Town		or Rural Route Number,		
)	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	29a. Certifier 1 ☐ Certifying Physician: To the best of Check 2 ☐ Medical Examiner: On the basis of only one) 3 ☒ Certifying Nurse Practitioner: To the control of the con	examination	and/or invest	gation, in my opinio	on, death occurred a	t the time, date an	d place, and due t	o the cause(s) and manner stated.		
			29b. Signature and title of certifier	CR	np	29c. License	90419	9 2	9d. Date signed ((Month, Day, Year)		
	XCA		30 Name and address of person who completed cause of Paige Wildman 100 E. Carr	death (Item :	23a) (Type, P	rint)	1.21801	1				
Ī	Stat Registra	-	Paige Wildman 100 E. Carr 31. Date filed (Month, Day, Year) SEP 19 2011	rar's Signatu	ire A.	bare						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Of Waryland State Regis Aumended Box#19b per FH WSH 31392 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 12, Physician/ 2011 5:03 TOBLAS ALBERT BOWERS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral **X** M 2 □ F Country) 56 172-46-3587 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA Adams Littlestown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code r items 23a or iner must be n 10g. Citizen of What Country? Funeral 246 St. John's Rd., West 17340 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 **X** No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Dump Truck Driver Elementary/Seconday (0-12) 12 College (1-4 or 5+) Heavy Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Lloyd Bowers Ruth Rodkey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 703 19a. Informant's Name/Relationship (Type, Print) <u>Scott A</u>.Bowers **S**on 5309 Henden Wood Lane, Frederick, ME 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Piney Creek Cemetery 9/16/11 Taneytown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility ittle's F.H. 34 Maple Ave. Littlestown, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Hupoxemiz disease or condition resulting in death) Medical Examiner din Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury ~e na that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/1 No Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Tes 1 M Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pendina work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35106 Sept 12, 30. Name and address & person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Seventh St., Frederick,

300 W.

32 Registrar's Signature

Nam,

MD

Myung

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3 | 3 9 3 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 Da**ĭ** 4 Physician/ 2011 2:50 AM Frank E. Boyd Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia Vantage House 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 🖾 M 2 🗆 F Days Hours Min 3Months Day 9916 214-12-8349 95 Vrs **Director** Usual Residence of Deceder 28a-f show at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director must be notified 1 Yes 2 XNo Columbia MD Howard 0 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral United States 5400 Vantage Point Road 21044 death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Forces? Black, White, etc. 5 ģ 1 Never Married 2 Married 1 ★ Yes 2 □ No If Yes, Give Year or Dates. ₩₩፲፲ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify "natural", Specify: Completed 3 XWidowed 4 Divorced White Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. I other than " Naval life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Electrical Engineer Research Laboratory 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked c ပ္ Bertha Otelia Warlitz Frank Orlando Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or any 3269 Danmark Dr. Glenwood, MD 21738 Charles M. Boyd/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Ardent Cremation Svc. 9-16-2011 Hanover, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee lla 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Renal Cancor Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami physician and the burial-transit Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 | Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of Was an has autopsy performed? death? After this certificate 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending **X**Natural work? 5 Pending injury 2 No death Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, 4 Homicide hours after City or Town, State) Medical Certifying Physician: The best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier npleted (Check 3[Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

building, etc. (Specify)

Description of the part of t

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day SEPT. 2011 V. Di BLASI 1325 JOSEPH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 🛛 M 2 🗆 F Months MARYLAND Director Yrs 219-28-9019 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No DELAWARE SUSSEX SELBYVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37267 DIRICKSON CREEK RD. 19975 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed WHITE the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DESIGNER GAS & ELECTRIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. မ ROCCISSNA JOSEPH V. Di BLASI SR. PHTLOMENA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEANNETTE H. DI BLASI/WIFE 37267 DIRICKSON CREEK RD., SELBYVILLE, DE 19975 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 Domation CREMATORY OF DELMARVA 9/17/11 DELMAR, DELAWARE 5 C Other (Specify) 21. Signature of 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on each line. the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final strike Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ilaillotion. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 nknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 2 No ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** æ 26. Place of Death (Check only one) examiner? Certificate: To 2 🗷 No Other: 1 🗌 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this tuneral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No filled in by the Accident Investigation Could not be 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10064120

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AQU 9733 Healthway Drive Berlin

32. egistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Atifzershan 31. Date filed (Month, Day, Year)

SEP 16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month C1 Physician/ **DOLORES** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula Regional medicul alisburi Wicomico 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months 1 □ M 2 🕱 F Hours MAY 20. PENNSYLVANIA 77 Director 1934 185-26-8323 Usual Residence of Decedent 10a, State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1 Tes 2 No DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Completed by Funeral 38867 ROOSEVELT AVE. 19975 USA ral", or items 2 Examiner mus Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE If Yes, Give "natural" 3 X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12College (1-4 or 5+) and Mental Hygiene. is marked other tha SECRETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GRAZIANT IRENE BARDOW traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a JOHN W. BEERS/SON 38864 GRANT AVE., SELBYVILLE. DE 19975 other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otf 20c. Location - City or Town, State cemetery, crematory or other place)
ARLINGTON NATIONAL 1 XBurial 2 Cremation 3 Removal from State UNKNOWNYARLINGTON, VA Donation 5 Other (Specify) 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ MESCIR ATORY disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to his nedlat cause. Enter Underlying -transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical certificate be the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, REN AL Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy page Yes 2 No 1 Yes 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 💆 No 욘 1 ■ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury n 24 hours after death.

e Funeral Director: After the function of the functin 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

12/5

State Registrar md. 2180

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E

Registrar's Signat

Dennis Chodnicki

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

de Blizzard		1- For State	State of Maryland		rtment of tificate of		nd Mental		99. No. 2011	31396
Physici edical Exami		1. Decedent's Name (First, Mi Jade	Lee		Blizzard			2. Date of Deat Month Septembe	h	3. Time of Death 2109 hrs
		4a. Facility Name (if not institu)	41		or Location of De		4c. County of Death	1
Funeral		5. Social Security Number		ge (In yrs. Ia	ist birthday)	Cresaptow If Under 1 Ye	ar If Under 24		th(MM/DD/YYYY) 9. Bir	300
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MD 21215-0036 Id 2 should be filed within 72 hours after that and Medical Hygene. In 27 is marked other than "natural", aumatic event, the Medical Examiner.	Com	17. Father's Name (First, Midd	ile, Last)		noste	ss/barte		me (First, Middle, M	Restaura Maiden Surname)	anı
2121	o Be	Danny BI 19a. Informant's Name/Relation			19b. Mailing	Address (Stre		thy Daws		^{3, zi} NG ^a 21502
≥ 5 4 2 5		19a. Informant's Name/Relatic Danny Blizz 20a. Method of Disposition	zard fa ————	ther	Place of Dispositi			Date La	Vale 20c. Location - City or	
Baltimore, permit. Pages 1 ar Department of Hea Important: If ite injury or other tr		1 Burial 2 Cremat		tate c	rematory or othe stlawn Me	r place)		9/29/2011		MD
Saltin ermit. P espartme mportar njury or		4 Donation 5 Other Signature of Funeral Pro	ice Licensee	11111				al Home, PA	2474.0	
Physician	A 1.5	23a. Part I. Enter the disease, failure. List only one cau		the death.	Do not enter the				erland, MD 2150 est, shock, or heart	Approximate Interval Between Onset and
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funcral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/N	23b. Was decedent pregnant in past 12 months?	4 Pregnant a	t time of dea	- H	I death 3 er (Specify)	Ectopic pres	gnancy	Month	Day Year
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of Vital Records, as Physician: The law require the true continues certificate has been simeral director, page 2 should b	Completed					_			sy prior to med? death?	utopsy findings available completion of cause of
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Division of tall or Attending as after death. The all Director: All led in by the fur	ation		28a. Date of Injunction (Month, Pay Sep 24, 201)		2105 hrs		Yes 2♥ No		auto collision	
Division pital or Attencours after death ceral Director: filled in by the	Certification:		ould not be atermined 28e. Place of Ir		me, farm, street, I / Highway	factory, office	building, etc.	or Town, S	Street and Number or Ri tate) en Highway, Cresap	
To the Hospital within 24 hours To the Funeral	Medical C	(one or or or	Physician: To the best of m							
To 1 with To 1	Med	29b. Signature and title of cert	and manner stated.				se number		29d. Date signed (Mo	
2.2		30. Name and address of pers	on who completed cause of	death (Item 1	23a)	0.0	,M.E.		September 25, 2	2011
7-Ay		Ling Li, MD Assis	tant Medical Examine	r 900 V	V. Baltimore	Street, Ba	ltimore, MD	21223		
St Regist	ate trar	31. Date filed (Month, Day, Yea OCT 0 3 201	(r) 32. Registra	ar's Signatur	and					

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Physicia	n/	1. Decedent's Name	,									2. Date of D Month		ay .	Year		of Death
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Examin	er	ShadyGro							Rockvi		TOT Death			Mont			
Funeral		5. Social Security No		6. Sex 1 🕅 M	2 🗆 F	'. Age (In yrs		day) If U rs. Mon	nder 1 Year ths Days	If Unde Hours	er 24 Hrs. Min.	8. Date of B	irth	year) 9. Birthplace (State or Foreign Country) New York			
Director		095-16-20 Usual Residence of				88		15.		<u> </u>		0//1//	1923				К
28a-f sho	ctor	10a. State MD	10b. County	tgome	rv	1	ckvi	or Location 11e								10d. Inside	City Limits
or 28a-f	Funeral Director	10e. Street and Nun		-80					. Zip Code				10g. C	itizen of W	/hat Cou		63 2 🗆 100
S/2+/ with with the mms 23a or 28 must be noti	eral	8 Baltin	more Ro	oad					20853					Unite	ed S	tates	
death ritem		11. Marital Status			Armed Ford	ent Ever in U	J.S.	13. Was D If Yes,	ecedent of H specify Cuba	lispanic O an, Mexica	rigin? (Spe an, Puerto	cify Yes or No Rican, etc.))-		e - Ameri k, White,	can Indian, etc.	
プレイとら 21215-0036 within 72 hours after giene. er than "natural", o the Medical Exam	ed by	1 ☐ Never Marri 3 🛣 Widowed			1 X Yes 2 If Yes, Give Year or Date		i-194	5 1□Y	es 2ဳ No	Specif	fy:			Specify: White			
/ < S 15-00 2 hours "natura edical E	plet	(Spe	15. Deceder cify only highe				(Give kind o	Usual Occup f work done	during mo	st of worki	ing	16b. Kind of Business Industry			-	
2121 2121 Juithin 72 ygiene. her than nt, the Me	Completed	Elementary/Seco	onday (0-12)	(College (1-4	or 5+)			r use retired) cal En		er		Com	elli muni	te cati	ons	
nd nd filed w all Hygig	Be	17. Father's Name (F		_ast)		,		00011	CGI DI			e (First, Middle	e, Maider	n Surname)		
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Waryland Maryland O Should be filed adth and Mental Hy and T is marked out or T is marked out		19a. Informant's Na David Cle			Print)							al Route Numb Lersbur				Code)	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the mayland permit. Page 1 and 2 should be filed within 72 hours after death with the may land Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Donation	Cremation		noval from S	State	cemetery		(Name of or other place Garden		_	Date .9/2011	1	ney,	•	own, State	
Baltir Permit. P Departm Importar any injur		21. Signature of Fur			M	01163		-								50	
m 20589		22a Port I Prior	Signature of Funeral Service Licensee M01163 Edward Sage of Facility Pike Rockville MD Sa. Part 1 Enterne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											208	5Z Approxim	nato	
Ph sician/		shock of hear Immediate Cause (I	t failure. List o Final	only one ca	use on each	h line.		ne cont	i mare e	ig, 30011 a	o darando c	or respiratory t	arrost,			Interval B Onset an	Between
Medical Examiner		disease or condition resulting in death)	n	a	Due to (o	r as a conse		CCAA	MMI							Minu	+25
	ē	Sequentially list con if any, leading to im- cause. Enter Under	nditions,	b. –	Due to lo	r as a conse	- Contract of the last	poyi	a					,	-	minu	utes_
ped Te	Examiner	Cause (Disease or i	injury		ac	ute			dio	~			11	WINER !	ĺ	mini	utes
9 F 5	- 1	that initiated events resulting in death) L	ast_	C	Due to (o	r as a conse	equence of):				- ONED BY	MEDICAL	EXHim			
760 cate be physic the bu	edic			d	Cho	king				CER	TIFICATION	PPROVED BY					
Box 68760 death certificate be attending physical for use as the beat for use as the b	M/ue	IF FEMALE: 23b. Was decedent				ome of preg		3 Fete	pic pregnan				ļ	23d. Dat	e of deli	very	
BO) ne death the att	Completed by Physician/Medica	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No			ant at time o			er (specify) _					Мо	nth	Day	Year
P.O. s that the gned by oe deta	by PI	Part II. Other signifi	icant condition	ons contrib	outing to dea	ath but not r	esulting in	the underly	ring cause gi	ven in Par	rt I.					the cause o	
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on of ending P eath. or. After t	ficate:	27. Manner of Death Natural Accident	5 Pendir	ng gation {	28a. Date o <i>(Month</i> 3 / 24 / 2	, Day, Year)	28b. Tii inj unk	me of jury P M	28c. Injui wor 1 🗆	yat k? Yes 2	X No	^{28d} Describe subjec food	how inju	oked	on 1	oolus	of
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could determ		28e. Place o building AS	of Injury - At g, etc. (Spec 5 1 S C e d	home, farr Livi	n, street, fa Lng Fa	ctory, office acilit	У		28f. Location City or To Rockvi	(Street a own, Stat 11e	nd Numbe te) 8 I MD	ar or Run Balt	il Route Nu. imore	Road
e Hospit 124 hour e Funera	Medica	(Check 2	Certifying Medical E	xaminer:	On the basis	of examinat	ion and/or	investigatio	n, in my opini	on, death	occurred at	t the time, date	and place	ce, and due	to the c	ause(s) and	manner stated.
To th To th comp	_	29b. Signature and			1				29c. Licens			_				, Day, Year)	
(2)			10	1		ر م	M	J Dull 15	2)	17	340	/	146	igu		25,3	
		30. Name and additional Angelo	Fal	CO W	e mi	D 9	901	med	dica	CH	r D	x R	ock	باأراد	e 1	nd 2	0220
Stat Registra		31. Date filed (Month		2011	Centre. Her	gistrar's Sigr	J. A	ach	W.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-07153 31398 Christopher Patrick Carney 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day September 22, 2011 **Medical Examiner** 2342 hrs Christopher Patrick Carney 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert 370 Longhorn Circle 5. Social Security Number 7, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Director Months Hours Min Country) Washington. 1⊮M 2 F 09/23/1978 213-08-7878 32 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 % No or items 23a or 28a-f sho must be notified at once, permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Calvert Lusby Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 370 Longhorn Circle 20657 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 🔆 Never Married 2 Married 2 * No 1 Yes 4 Divorced 3 Widowed If Yes, Give Year 1 Yes 2 1 No specify: Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 IT Company Certified IT Technician 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Charlotte Betty Rosenthal Martin Murray Carney, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ₩. Martin M. Carney, Jr./Father 370 Longhorn Circle, Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Itimore. crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 10/01/2011 Metropolitan Crematory Alexandria, Virginia Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service License Rausch Funeral Home, P.A. echael Keven P.O. Box 600, Lusby, Maryland 20657 23a. Part I. Enter the disease, or complications that guised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death Immediate Cause (Final disease Narcotic (morphine) Intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f per me g920 10-5-11 vt **X** UNPENDED attending physician for use as the burial -Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Dav past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for 9 Unknown is been signed by the should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of icate has page 2 sh performed death? After this certificate I ✓ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 Yes 2 X No Pending Director: fd 9-22-11 fd 11:27pm unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be or Town, State) 370 Long Horn Circle To the Hospital within 24 hours al To the Funeral E completely filled determined (Specify) found at home 4 Homicide Lusby, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 23, 2011 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year, State

Registra

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 09 2011 9:44 Donald Raymond Cummins, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Calvert Memorial Hospital Prince Frederick Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 🗶 M 2 🗆 F 0471071958 214-72-4926 Director 53 Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location Director 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified 1 Yes 2 X No MD Calvert Chesapeake Beach ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 4002 Old Bayside Road 20732 United States "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 2 1 Never Married 2 Married Yes 2 X No within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: Completed 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Donald Raymond Cummins, Sr. Jean F. Wyvill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Deborah Wood / Sister 27150 Barton St., Mechanicsville, MD 20659 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Oak Cemetery Mt 09/23/2011 Mitchellville, MD 21. Signature of Funeral Service Lic 21. 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 Amanda M. Ergler 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) esopha Q month Medical Due to (or as conseque ce **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) and I-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 Live Signature of death signed by the atter in the past 12 months? Yes 2 No g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? page performed certificate | 2 No 2 - N 1 Tes 24 hours after death, Funeral Director. After this certifical et al. 1997 in the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical within 24 hou

To the Funer

completed fil 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signati 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) teu)

DHMH 17 Rev 7/2009

State Registrar OWI

32. Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ September 11, 2011 6:55 p M Jean Jones Chenoweth Medical 4a. Facility Name (if not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Country Care Assisted Living Westminster Carroll 8. Date of Birth 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In yrs. last birthday) May 21, 1923 Days Hours 1 M 2 X F Virginia Director 230-24-4315 88 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Carroll Taneytown 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 309 Taney Heights 21787 USA death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married within 72 hours after Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white If Yes, Give than "natural", 3 X Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည Department of Health and Ment. Important: If item 27 is marken any injury or att. Alpheus Jones Anne Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Whiffletree Way, Dothan, AL 36303 Kristin Tolar, daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of condidate Cematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 9/13/2011 Winfield, MD Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition neumon Medical resulting in death) Examiner Sequentially list conditions, If any, reaching to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 🗶 No 9 Unknown 9 Unknown Records, P.O. is been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an as e 2 autopsy page perform death? this certificate Yes 2 N 1 ☐ Yes 2 ☐ No : After this certifica funeral director, p **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted Living examiner? Hospital: Other: 2 **X** No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 Yes 2 No 1 X Natural 5 Pending within 24 hours after death

To the Funeral Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number 29d. Date MO Idress of person who completed cause of death (Item 23a) (Type, Print) 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

State

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

permit.

Saltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

or Attending Physician: The law requires that the death certificate be

Registrar

31. Date filed (Month

cause of death (Item 23a) (Type

Physician	
/Medical	
Examiner	

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "raturar", or items 23 or 28a-f show any injury or other traumatic event, I'm Medical Evaninating the notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Stat

	for State Registrar	otato of Mai	ylaria / D	Certificate o	f Death	Re	g. No.	31402
	1. Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
n	Thomas Collin	S				Month 7	Day 2011 Year	2050 p M
al er	4a. Facility Name (If not institution, giv		Sn	4b. City, Town	, or Location of Death		4c. County of Deat	
	Harrison Seni	or Living			Hill		Worcest	er
П	5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birth		ar If Under 24 Hrs.	8. Date of Birth (Month, Day,	year) 9. Birt	thplace (State or Foreign ountry)
	218-12-1989	X M 2□ F 99	Υ	rs. Months Day	s Hours Will.	8-18-1		
	Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town	or Location				10d. Inside City Limits
č	Tob. County		-					1 ☐ Yes 2 🔯 No
ect	VA Accoma	ck	New Ch			1 40	og. Citizen of What Co	
ă	10e. Street and Number			10f. Zip Code	9			ountry :
eral	7067 Pearl Dri	VE 12. Was Decedent Ev	er in II.C	23415	f Hispanic Origin? (Sp		SA 14. Race - Ame	orioan Indian
Ë	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ▼ No		If Yes, specify C	uban, Mexican, Puerto	Rican, etc.)	Black, White	
ģ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 X N	lo Specify:		Specif B la	ck
Completed by Funeral Director	15. Decedent's Ed	ducation		Decedent's Usual Oc		I 1	6b. Kind of Business	/Industry
ple	(Specify only highest gra	ade completed) College (1-4or 5+)		Give kind of work dol life. DO NOT use ret	ne during most of worki ired)	ng		
Š	8		I	borer		L	umber Mi	11
Be (17. Father's Name (First, Middle, Last,)			18. Mother's Name	e (First, Middle, M	laiden Surname)	
٥	Lloyd Collins				Maggie	Staton		
	19a. Informant's Name/Relationship (Type. Print)	19b. I	Mailing Address (Stre	et and Number or Run	al Route Number,	City or Town, State,	Zip Code)
	Brenda Fosque							MD 21851
	20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐	Removal from State	20b. Place of C cemetery	Disposition (Name of crematory or other	LC	Date 2	20c. Location - City or	Town, State
	4 □ Donation 5 □ Other (Specif		Direc		ion,9-16-			
	21. Signature of Funeral Service Licer	nsee		Bennie and Ad	Smith 91	7 W. Is	abella S	t.
	Much	M			Home Sal		113	
	23a. Part1. Enter the dise ve, or conshock, or heart failur. List on	dications that caused the one cause on each line.	ne death. Do no	ot enter the mode of o	lying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	ATHERO	SCLER	OTIC CAR	DIOVASCU	LAR DI	SEASE	Onset and Death
	resulting in death)	Due to (or as a						
_	Sequentially list conditions,	b						
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a r	consequence of).				
xar	that initiated events resulting in death) Last	cDue to (or as a	consequence of	i):				
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⋝	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		_			23d. Date of de	livery
icia	in the past 12 months? 1 □Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti		3 ☐ Ectopic pregna 5 ☐ Other (specify)			Month	Day Year
Physician/	9 ☐ Unknown	9 ☐ Unknown				_		
J Y	Part II. Other significant conditions of	contributing to death but	not resulting in t	the underlying cause	given in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
Completed by						1 □ Ye	s 2 No 3□P	robably 4 Unknown
plet						24a. Was an	24b. Were a	utopsy findings available
E 0						autopsy perform	y prior to ned? death? L⊠No 1 ∐ Ye:	completion of cause of
De C	25. Was case referred to medical				26. Place of Deatl			3
	examiner? 1 ☐ Yes 2 █ No	Hospital: 1 ☐ Inpatient	2 🗌 ER/Outr	patient 3 DOA			nce 6 ☐ Other (Spe	ecify)
	27. Manner of Death	28a. Date of Injury (Month, Day,	(ear) 28b. Tin	me of 28c. In		28d. Describe ho		
atic	1 Natural 5 Pending 2 Accident investigation	1	"",		☐Yes 2☐No			
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	- At home, farm	n, street, factory, offic	e	28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
ē								
0		mainian. To the heat of	my knowledge,	death occurred at the	time, date and place, y opinion, death occur	and due to the cared at the time, da	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
cal	(Check only 2 Medical Exar	niner: On the basis of e						
Medical C	(Check only 2 Medical Exar	niner: On the basis of e and manner state		00- 11-	anno number:		Od Dote oi /44	th Day Vans
Medical Certification: 10	(Check only 2 Medical Exar	niner: On the basis of e and manner state	d.		ense number 62172	29	9d. Date signed (Mon	
Medical C	(Check only 2 Medical Exar	niner: On the basis of e and manner state	d.	D		29	9d. Date signed (Mon	
Medical C	(Check only one) 2 Medical Example Medical Exa	niner: On the basis of e and manner state	th (Item 23a) (T	Vipe, Print)	62172		9191201	1
Medical C	(Check only 2 Medical Exar	completed cause of dea	d. (t) (th (Item 23a) (T	Vipe, Print)	62172		9191201	

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician/ Month September 26 ames Carl 2011 Facility Name (if not institution, give street and number) Horasant View Nursing Horasant National Pike Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Home 4101 Old Social Security Number arrol tiona ount If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F Months Days (Month, Day, 219-24-7868 Usual Residence of Decedent Yrs Director 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland 10e. Street and Number 20500 l lour 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. à 1 Never Married 2 Married 72 hours after 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Trucking)rivea Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James C 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If item 27 is n Moryland, 21539 8 East Main Street Jones McKenzie-Funeal Director Longiconing 20a. Method of Disposition 20b. Place of Disposition (Name of 200 Docation - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Septembe 4 Donation 5 Other (Specify) 2 2011 Frosthusc 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn - Monenzie Funeral Home PA Mehry 8 East Main Street Lonaronina 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ INFARCTION TYOCARDIAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Exam requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown g | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given In Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by PARKINSON'S DISEASE 1 Yes 2 No 3 Probably 4 Unknown Non. Insulin Dependent Drabeter 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No Chronic obstructive Dinesie Pulmonary 1 Yes 2 No or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifit 29c. License number 467 29b. Signature 29d. Date signed (Month, Day, Year) Soplember 27, 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 PARKWAY, # 308;

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

OCT 0 3 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

11-06857

Amend 26 per OCME G920 10/6/11 dk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alice Elizabeth Davis State of Maryland / Department of Health and Mental Hygiene 2011 31404 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3 Time of Death Month Day Year September 11, 2011 **Medical Examiner** 1700 hrs Alice Elizabeth Parsons
4a. Facility Name (if not institution, give street and number) Davis 4b. City, Town, or Location of Death 4c. County of Death Wooded Area off MD Route 529 Princess Anne Somerset 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) Davs Hours Director Country) Maryland 1 M 2 X F 220-66-4946 55 12-18-1955 Usual Residence of Decedent io, 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 X No **21215-0036** Solution 72 hours after death with the Maryland MD Allen Wicomico Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? <u>3574 Allen Road</u> 21810 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, 1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No 4 Divorced If Yes, Give Yea 1 Yes 2 X No specify: Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than ", it. Pages 1 and 2 should be filed within 7 trument of Health and Mental Hygiene. artant: If item 27 is marked other that 7 or other traumatic event, the Medics 7 or other traumatic event, the Medics Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Casev Parsons Belle Smith Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Barrie Tilghman - Sister</u> 1009 Monitor Court, Salisbury, Maryland 21801 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department o 4 Donation 5 Other Specify: Crematory of Delmarva 9-16-2011 Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee Salisbury, Main Street, Maryland 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Approximate Interval failure. List only one cause on such line Between Onset and (Martine) Death a. Blunt Force Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and led for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed After this certificate has been suneral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of performed? ✓ Yes 2 No death? 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 FROutpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 Yes No 28a. Date of Injury FOUND: Pay, Year) 27 Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Subject was assaulted Natural FOUND: Pending 1 Yes 2 ✔ No 24 hours after death. completely filled in by the To the Funeral Director: Sep 11, 2011 1700 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Wooded Area off MD Route 529, Princess Anne, MD determined (Specify) Woods 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 12, 2011 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year) SEP 1 6 2011

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 Helen Elizabeth English 2011 0429 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 08/26/1927 1 □ M 2 🗓 F Hours 203-20-9261 Director PA 84 Usual Residence of Decedent show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 ☐ No MD Carroll Taneytown 10e. Street and Number 10f. Zip Code 5 10g, Citizen of What Country? 23a Funeral 123 Morning Frost St. 21787 USA items hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Force Black, White, etc. ō 1 Never Married 2 Married þ 1 ☐ Yes 🌠 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3X Widowed 4 ☐ Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Pharmacy Technician Giant Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lisle Marlin Cupp Charlotte E. Campbell f and 2 should b f Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Morning Frost St., Taneytown, MD Yvette Matrey/daughter item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite ō 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lakeview Memorial Park 09/03/2011 Eldersburg, MD Signature of Funeral Service Licer 22. Name and Address of Facility Pritts Funeral Home & Chapel 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ oronar disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 2 should be detached for Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4- Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No the Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature nd title of cert License number 30. Name and address of person who completed cause of death (Item 23a) (Type Print)
TAPIO MA LMOUN 9, 19 32. Redistrar's Signature State recen

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2011 31406 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Certi	ficate of L	Death		,,,	Reg. I	No.		
Physici		Decedent's Name (First, Middle,	Last)						Date of Death	av Yea		3. Time of Death
Medical Exami	ner	Stephen Bernard						5	September 9	, 2011		1159 hrs
		4a. Facility Name (if not institution,	-				or Location of	f Death		4c. County c		
		508 Rambling Sunset C				Mount Air				Frederic		
Funeral		Social Security Number 6	. Sex 7. Age	e (In yrs. last	t birthday)	If Under 1 Ye Months Da		Min. 8	. Date of Birth (N	MM/DD/YYYY	9. Birtl Foreign	
Director		214-39-5934	X M 2 F	18	Yrs.	WOTERS	ays nours		June 2,	1993		Tryland
		Usual Residence of Decedent										
4 any		10a, State 10b, County			own or Location	1						10d. Inside City Limits
and sho	ō	Maryland Frede	erick	Mt. A								1 Yes 2 X No
Aaryland 28a-f show 1 at once.	ect	10e. Street and Number				10f. Zip Code			10g.	Citizen of Wh	at Coun	try?
the N	ral Director	508 Rambling Sur	set Circle			2	1771		11.	nited	Stat	· e s
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygene. teat 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Ta	11. Marital Status	12. Was Decedent	Ever in U.S.		Decedent of H	14. Race	- Americ	can Indian, Black,			
death r iter	Fune	1 X Never Married 2 Marr	ied Armed Forces?	X No	If Yes	, specify Cub	an, Mexican, I	Puerto Ric	an, etc.)	White	, etc.	
after ul", o	by F	3 Widowed 4 Divorce	ced If Yes, Give Year		1 Y	es 2 X	lo specify:			Specify:	Whi	te
ours :		15. Decedent's Education (Specify	only highest grade com	pleted) 1	6a. Decedent's	Usual Occup	ation (Give ki	ind of work	done 16	b. Kind of Bus	siness/Ir	ndustry
72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	auring mos	t of working if	fe. DO NOT u	ise retired)				
og rithin r th	Ę		1		:St	tudent				Coll	ege	
5-0 Hygi		17. Father's Name (First, Middle, La	ast)				18.Mother's	Name (Fir	st, Middle, Maid	len Surname)		
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	B	Bernard F. Frye					Mary	Bix1	er			
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than sumatic event, the Medica	မ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing A	ddress (Str	eet and Numb	er or Rura	Route Number	, City or Town	, State,	Zip Code)
ME 3d 2 s alth as alth as 27		Mary Frye/ Mothe	er		508 Ran	nbling	Sunset		cle, Mt	. Airy	,Mar	yland21771
Baltimore, MC permit. Pages 1 and 2 sl Department of Health an Important: If item 27		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from Sta		ce of Disposition	on (Name of c r place)	emetery,	Da	ate 20	c. Location -	City or T	Fown, State
Page lent o		4 Donation 5 Other Spec			ıffer Cı	remato	rv Inc	.9/11	/11 F	rederi	ck.N	Maryland.
alti mit. partm		21. Signature of Juneral Service Lie			22. Nan	ne and Addre	ss of Facility	- 1 77 -	, <u>I</u> -	A		101 / 10110 :
E.E.G.E		Model 1)(///x/i	1	- 162	luffer 21 Opos	a. derick	,Mar	yland21702			
Physician		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Ma 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
/Medical //xaminer			a. Shotgun Wound	of Head								Between Onset and Death
ZAAIIIIIEI		or condition resulting in death)	Due to (or as a conse		_							
		Sequentially list conditions,	b									
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):								
	Examiner	(Ulssase or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):								2
outed nd ransi			d									
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED									
760, icate be physici the buri	ĕ	IF FEMALE:	23c. If yes, outcom	e of pregnan	псу	_				23d. Date of c	delivery	
x 687 h certific tending p		23b. Was decedent pregnant in the past 12 months?	1 Live birth			death 3	Ectopic p	pregnancy		Month	Da	ay Year
Box 687 e death certific the attending of the tree as the	Si	1 Yes 2 No 9 Unkno	Pregnant at t	ime of death	5 Other	(Specify)			//			
O. B. tr the de by the ached f	Physician	Part II. Other significant condition	9 Unknown	but not soon	diania dia cond		alum in Bad	. 1	O2a Dividabas			ne cause of death?
		Tat ii. Other significant condition	e contributing to death	but not resu	nung in ure ana	enying cause	given in Part	i I.	_		_	ably 4 Unknown
rds, P.(requires tha been signed hould be det	Completed by		-	_								
ord w rec as bee	Be								24a. Was an autopsy	pr	ior to co	opsy findings available empletion of cause of
Division of Vital Records, talor Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the fineral director, page 2 should be	ē								performed 1 ✓ Yes 2		eath? ✔ Yes	2 No
ician: 'icertific	Be	25. Was case referred to medical				26.Plac	e of Death (C	heck only	one)			
Vit.	٥l	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	t 2 ER	₹/Outpatient 3	DOA	Other4	Nursing Ho	ome 5 Res	idence 6 🗸	Other:	Scene
n of ding Ph	Ë	27. Manner of Death	28a. Date of Injur	y 28	Bb. Time of Injui	ry 28c. Inj	ury at Work?		. Describe how		d	
ion tendi tor: .	읥	Natural 5 Pending Accident Investig		11	145 hrs	1	Yes 2 🗸 N	40 SUE	oject shot se	ell.		
ViSi or At fler d in by	ij	3 ✓ Suicide 6 Could n	28e Place of Init	ıry - At home	e, farm, street, f	factory, office	building, etc.					al Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	4 Homicide determin		gle Family	/ Home			508	or Town, State) Rambling Sui	nset Circle,	Mount .	Airy, MD
Hos 24 hc Fun		29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge,	death occurred	at the time,	date and place	e, and due	to the cause(s)	and manner a	as stated	d.
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical	one) 2 Medical Examir	ner: On the basis of exam and manner stated.	ination and/	or investigation	, in my opinio	n, death occu	urred at the	time, date and	place, and du	e to the	cause(s)
FSFö	×	29b. Signature and title of certifier				29c. Licen	se number		29	d. Date signe	d (Mont	h, Day, Year)
		0-70-	-			0.0	.M.E.		S	eptember	10, 20	111
	-	30. Name and address of person wh	o completed cause of de	ath (Item 23	a)							
		Donna M. Vincenti, MD	Assistant Medica	al Examin	er 900 W	. Baltimor	e Street, B	Baltimore	e, MD 21223	3		
St	ate	31. Date filed (Morris, Day, Year)	32. Registrar	s Signature	Low	1.1						
Regist	rar	4	James	for	· 269 6000	or Care						

DHMH 17 Rev 1/2001 OCME 2006

OGME

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31408 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donnie Ray Farmer 0010 Medical Sept 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 ★ M 2 □ F Country)
NC Months Min. Aug 6, 1948 218-48-8466 Hours **Director** Usual Residence of Decedent show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Berlin 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10530 Flower St. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married □xYes 2 □ No Army Yes, Give Baltimore, Maryland 21215-0036 African-1 Yes 2 No Specify. Completed 3 X Widowed 4 Divorced Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Food Manufacturer Laborer injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment. Important; If item 27 is marked any injury or net. unknown Flossie Farmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa Rounds/sister P. O. Box 184, Selbyville, DE 19975 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul's Cemetery 9/17/2011 Berlin, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lewis N. Watson Funeral Home, PA
1618 West Rd., Salisbury, MD 21801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of burial-transi Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be as IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Dav Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 645 30. Name and address of person wit

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day YOLANDA GRIFFIN 23:40 P M SEP 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ATLANTIC **GENERAL** HOSPITAL MARYLAND BERLIN, WORCESTER 5. Social Security Number | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | MAY 12,1960 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X F Months 221-44-5928 SELBYVILLE, DE Director 51 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director DELAWARE 1 Yes 2X No SUSSEX COUNTY SELBYVILLE 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 37956 LINCOLN AVENUE 19975 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married and 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MAINTENANCE WORKER MUNICIPAL GOV'T. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ and 2 should be WILLIAM MUMFORD CORINA SHOWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 ELISHA GRIFFIN (HUSBAND) permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other to 37956 LINCOLN AVE., SELBYVILLE, DE 19975 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State FIRST ST. CREM. CTR. 4 Donation 5 Other (Specify) MILLSBORO, DELAWARE SEP 19,2011 21. Signa (Licensee 22. Name and Address of Facility 19966 MO 1361 WATSON FUNERAL HOME PO BOX 125 MILLSBORO. Part 1. Enter the disease, or combinators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Myocardial Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by atera 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy After this certificate performed? Yes 2 N 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Hospital or Attending Plant
 24 hours after death.
 Funeral Director: After the 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 | Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) C20005747 9/15 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 Laurel Rd. Millsboro DE Sa 31. Date filed (Month, Day, Wear) State 32. Reistrar's Signature Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:40 PM **JOHN** T. GRIFFITH Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner Wicomic 8. Bate of Birth **Funeral** Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 **x** M 2 □ F 155-42-1100 Director 60 Pennsylvania Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Maryland Crisfield Somerset 1 Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? or items 23a Funeral 3835 Walt Thomas Road 21817 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or i any injury or other traumatic auch. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2X No White 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cabinet Maker Wood Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Theodore Griffith Josephine A. Stoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mona Jean Griffith (Wife) 3835 Walt Thomas Road - Crisfield, MD 21817 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 **Cremation 3 **Removal from State Crematory of Delmarva 09/19/2011 4 ☐ Donation 5 ☐ Other (Specify) Delmar, DE 21. Signature En Servic Li 22. Name and Address of Facility
Bradshaw & Sons Funeral Home Bradshaw Robert H. 306 W. Main St. Crisfield 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. SOPHAGEA Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (r as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy yes 2 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 No Other: ည 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred V Natural 5 Pending Accident Suicide 1 🗌 Yes 2 🗌 No Investigation after death filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature

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31. Date filed (M

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 18, 2011 Year 7:45 p M Thomas L. Hall Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death South River Health & Rehabilitation Center Anne Arundel Edgewater Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 ▼M 2 □ F Hours (Month, Day, Year) August 20, 1911 Country) 100 Yrs. Director 215-32-1175 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 No MD Anne Arundel Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20758 USA 6866 Old Solomons Island Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced Year or Dates Black other than "naturent, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farmer .nit. Page 1 and 2 show.
--ertment of Health and Menta.
-- If item 27 is marked other
-- Ser traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rachel Sarah Holland Hoover Henry Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Trent Hall Court, Friendship, MD 20758 Malana Savoy - daughter Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cooper's UM Church Cemetery September 23, 2011 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Dunkirk, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee Sewell Funeral Home, P.A. 22. Name and Address of Facility 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Atheroscienotic Cardio vasculand Physician Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be cancer 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of Colon Concer 24a. Was an this certificate has autopsy performed? Yes 2 No death? Anaemia 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) funeral director, 1 ☐ Yes 2 ☑ No Hospital ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural injury s after death.

I Director: Af 1 🗆 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) yon 50653 9-20-2011 awono. SURANA den 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAIY

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State Registrar

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31. Date filed (Month, Day

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32. Registra s Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-06790 State of Maryland / Department of Health and Mental Hygiene Joseph Michael Haberski 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ **Medical Examiner** 1711 hrs September 8, 2011 Joseph M. Haberski 4a. Facility Name (if not institution, give street and number) 4c. County of Death) 4b. City, Town, or Location of Death Frederick Walkersville 8736 Treasure Ave 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Days Hours Director 1 X M 2 F 58 Pennsylvania 180-44-9283 .1953 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 1 Yes 2 X No 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once Maryland Frederick Walkersville 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 8736 Treasure Avenue 21793 Funeral 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. 1 Never Married 2 Married Armed Forces? Yes 2 X No 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed Specify: White É 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Heavy Equipment 12 Mechanic 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Walsh Stanley Haberski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18707 Pennsylvania Eileen Martin Sister 1361 St. Marys Road, Mountain Top. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory Inc.9/11/11 Frederick, Maryland. 4 Donation 5 Other Specify: ²² Name and Address of Facility Stauffer Funeral Homes 1621 Opossumtown Pike, 21. Signature of Funeral Service-Li P. A. Frederick, Maryland 23a-Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and Modical Death a Head Injuries complicating Chronic Alcoholism Immediate Cause (Final disease xaminerٹہ or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. Ś 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been rector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 No page 1 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Hospital or Attending Physician: Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene After this 1 Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Suject fell striking head UNKNOWN 1 Natural 5 Pending 1 Yes 2 ✔ No Director: · death. Sep 8, 2011 2 🗸 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 8736 Treasure Ave, Walkersville, MD c Funeral letely filled determined (Specify) Single Family Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Within To the and manner stated. 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie 29c. License number September 9, 2011 O.C.M.E. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar

Registrar DHMH 17 Rev 7/2009

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Baltimore, Maryland

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2011 A M 10 8:50 Sept. Norman Clarence Kerentoff /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Poolesville 15520 Mt. Nebo Road | FUNDES VILLE
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1**⊠** M 2□ F Ohio 96 July Director 292-03-4031 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 28a-f show ed other than "natural", or items 23a or 28a-f shovevent, it a Medical Examinational beaudified at 1 ☐ Yes 2 X No Director Woodstock Township, Manitou Beach Michigan Lenawee 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 49253 United States Funeral 5870 Lakeside Drive within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 □Yes 2KNo Specify: þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lumber Company nealth and Mental Hygie n 27 is marked other th region of traumatic ever of traumat 12 Owner / Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Hattie Ehlert Fred Kerentoff ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandra Lynn Kerentoff /Daughter 15520 Mt. Nebo Road Poolesville, Maryland 20837 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Manitou Beach, September 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 15, 2011 Michigan Green's Lakeside Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Juneral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Set only one cause on each line. Immediate Cause (Final \Physician Acute Myelogenous Leukemia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 Months Myelodysplautic Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examiner The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 0 signed by the a d be detached f ☐Yes 2 ☐ No 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No certificate 1 ☐ Yes 2X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify)Residence Hospital: 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending investigation 1 🔼 Natural the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) within 2. and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0063828 9/12/2011 of person who completed cause of death (Item 23a) (Type, Print) eath (Item 23a) (Type, Print) 9715 Medical Center Drive, Suite 435, Rockville, MD20850

Registrar DHMH 17 Rev 1/2001

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30. Name and address

Dongmei

Wang

M.D.

Registrar's Signature

Ammended Box #22 Per F.H.WSH Carroll County Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Erma Margarete Keyser 2011 Medical Διια 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 15303 Old Hanover Road Baltimore Upperco 5. Social Security Number If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 M 2 LX (Month, Day, Year) 11-28-1927 Country) 213-36-9521 **Director** 83 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 🗌 Yes 2 屎 No Upperco 10e. Street and Numbe 10f. Zip Çode 10g. Citizen of What Country? Funeral 15303 Old Hanover Road 21155 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married giene. er than "natural", 1 ☐ Yes 2 No Specify: If Yes, Give white 3 ★Widowed 4 ☐ Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other thready injury or other traumatic event, the 1 one. sewing factory seamstres Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Goldie Viola Heitzman Lionel Russell Osborn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 North Cape Horn Rd., Hampstead, Edith Hughes, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 StBurial 2 Cremation 3 Removal from State Reisterstown, Pleasant Grove UM 9/7/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Hampstead, MD 21074
934 S. Main St., Westminster, MD 21. Signature of Funeral Service Licensee M00741 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ METASTATIC disease or condition 16ARS Medical resulting in death) Due to (or as a consequence of) Examiner SMALL Sequentially list conditions, Examiner il any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown CARCINONA OF THE DESCENDING COLON 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 14 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 X No ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 peen certificate this

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

signed by the a d be detached f page 2 s Direc

24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Name Practionars T. the best of my knowledge coeth occurred at the time date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO 1663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jr. M.D., 447 E. Main St., Westminster, MD 21157

Fiocco, Vincent J. 31. Date filed (Month, Day, Year) Registrar's Signature rack

Registrar

11-07200 Amanda D. Mitchler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Manda D. Mile		1- For State Registrar	n waryiand /		tificate of				Reg. No.	3 4 1				
Physici Medical Exam		Decedent's Name (First, Middle,Last) Amanda Denise	Mitchle	r				Month Septemb	Day Yea Der 24, 2011	3. Time of Death				
		4a. Facility Name (if not institution, give			4	b. City, Town, o	or Location of		4c. County of	of Death				
		Calvert Memorial Hospital				Prince Fre			Calvert					
Funeral Director	8	5. Social Security Number 6. Sex 219-27-0443		` •	est birthday) Yrs.	If Under 1 Ye		Min.	9, 1986	9. Birthplace (State or Foreign Country) Maryland				
yna		Usual Residence of Decedent 10a. State 10b. County		I0c. City,	Town or Location	on				10d. Inside City Limits				
A .	ŗ	MD Calvert		No	rth Bea	ch				1 X Yes 2 No				
Maryl≀ • 28a-f •dato	Director	10e. Street and Number				10f. Zip Code	,	-	10g. Citizen of Wh	at Country?				
r death with the Maryland or items 23a or 28a-f sho must be notified at once,		8639 Chesapeake I	ighthouse			2071		? (Specify Yes or N	USA	- American Indian, Black,				
eath w	Funeral	1 XX Never Married 2 Married	Armed Forces?					Puerto Rican, etc.)	White					
after d	by Ft	3 Widowed 4 Divorced	f Yes, Give Year or Dates:	X No	1	Yes 2 N	o specify:		Specify:	White				
hours fnatur Exami	ed t	15. Decedent's Education (Specify only				's Usual Occup st of working lif		nd of work done se retired)	16b. Kind of Bu	siness/Industry				
36 hin 72 e. than '	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-+3	"	Man	ager			Resta	aurant				
5-00 led wit Hygien other		17. Father's Name (First, Middle, Last)						Name (First, Middle						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Richard Eugene 19a. Informant's Name/Relationship (Ty			19h Mailing	Address (Stra		ry Freels		State Zin Code)				
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	၀	Mary Weakley - Mc								ch, MD 20732				
re, N 1 and FHealth Fitem er trau		20a. Method of Disposition 1 XX Burial 2 Cremation 3	Romoval from Stat		lace of Disposit			Date	20c. Location -	City or Town, State				
Pages Pages nent of ant: I		4 Donation 5 Other Specify:			sapeake	Highla		ept. 30, 2011	Port Re	public, MD				
Baltimore, permit. Pages I ar Department of Hes Important: If ite		21. Signature of Funeral Service Licens	ee			ame and Addre				Calvert, P.A.				
Physician		Gary J. Goff 23a. Part I. Enter the disease, or compli-		he death.	Do not enter the	O Jen ni e mode of dying	<u>ter La</u> g, such as car	ne. Owing	rrest, shock, or hea	0736 Approximate Interval				
Examiner) n	failure. List only one cause on eac Immediate Cause (Final disease a.	n line. Complicat i	lons	of Toxe	mia of	Pregna	incy		Between Onset and Death				
Examiner		or condition resulting in death)	ue to (or as a conse											
	Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
	amir	if any, leading to immediate course. Enter U derlying Course (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
cuted ind transit	EX	d												
'60, sate be executed physician and ne burial - transit	Medical	■ UNPENDED	AMENDED 23a,	27 , p	er me,g	921 11-	-18–11	sm		H _a				
3760, ificate be g physici s the buri	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregn		al death 3	Ectopic p	regnancy	23d. Date of Month	delivery Day Year				
Box 6876 death certificate he attending phy d for use as the b	Physician/	past 12 months? 1 ✓ Yes 2 No 9 Unknown	4 Pregnant at t	me of dea	-41-	er (Specify)			Sep 23					
D. Bo: the dea: by the a	Phys		9 Unknown	but not re	sulting in the ur	nderlying cause	given in Part	1 23e. Did	tobacco use contri	bute to the cause of death?				
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	۾					,	3		es 2 No 3	Probably 4 🗹 Unknown				
ords, w requir s been s should!	Completed							24a. Wa		Vere autopsy findings available nor to completion of cause of				
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tal Rection: The certificate	BeC	25. Was case referred to medical examiner?				26.Plac	Oth	heck only one)						
f Vid Physic er this	P	1 ✓ Yes 2 No 27. Manner of Death	spital: 1 Inpatier		ER/Outpatient 28b. Time of In		Other ₄ 1	Nursing Home 5	Residence 6	Other:				
ion of tending Pheath. tor: After the funeral	ion	1 X Natural 5 Pending	28a. Date of Injur (Month, Day, Ye	ar)	200. Time of in	`	Yes 2 N		s now inquiry occurre					
Vision Afte the dear	ficat	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Init	ıry - At ho	me, farm, street	i, factory, office	building, etc.			er or Rural Route Number, City				
Divisior Hospital or Attend 24 hours after death Fuocral Director:	Certification:	4 Homicide determined	(Specify)					or Town,						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuorral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 ☐ Certifying Physicla (Check only one) 2 ✔ Medical Examiner:												
To the within To the comple	Medical		and manner stated.				nse number			ed (Month, Day, Year)				
		7/11/1	1. Kind	TA	14.	0.0	.M.E.	OCME	September	25, 2011				
		30. Name and address of person who co	•			<u></u>	mars 01:	A Deltine *	4D 24222					
	لب	Theodore M. King, Jr., MD.	Assistant Me			00 VV. Balti	more Stree	et, Baltimore, N	1D 21223					
S Regis	tate	31. Date filed (Month, Day, Year)	44 Sz. 159istial	o orginatul	h ha	Kel								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Physician/ 04^{bay} 2011 1:38 P M Mark Kevin Maisel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 5 Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Birtrip... Country) MD **Funeral** Months Hours 04/29/1960 1 🔀 M 2 🗆 F **Director** 216-78-2111 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits death with the Maryland item 271 is marked other than "natural", or items 28a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 ☐ Yes 2 No Carrol1 MD Sykesville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 21784 598 Noland Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces? 1 Never Married 2 X Married þ Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) af Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Construction Project Manager Be permit. Page 1 and 2 should be filed Department of Heath and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Barbara E. Smith Louis Maisel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
598 Noland Drive, Sykesville, MD 21784 Janice L. Maisel/wife 3altimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Pleasant Ridge Cem. 09/08/2011 Woodbine, MD Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Lie 22. Name and Address of Facility 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause yeach line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition) Medical resulting in death) to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Year Month Day 1 Yes 2 L 9 Unknown ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ moophes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 \sum Yes 2 \text{No} Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 🕅 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29b. Signature and title of continu 29d. Date signed (Month, Day, Year) DO022663

State Registrar 31. Date filed (Month, Day, Year,

SEP

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Ridge Rd asstminter md, 21157

Name and address of person visc completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Chesapeake Hospice House Harwood Social Security Number Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 □ F Months April 5 Days Hours Min. Mary Land 218-52-9144 **Director** 62 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖁 No Prince George's Clinton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20735 8206 Dangerfield Place within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. ۾ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Page 1 and 2 should be filed within 72 hours aften nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Trucks 12th Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Frances Conroy John Edward Murphy, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4856 Church Lane, Galesville, Maryland 20765 Kathleen O. Murphy/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 9/12/2011 Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) Juneral Septice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatu 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). auending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ၉ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA this 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred hours after death. Ineral Director: After 1 Natural 5 Pending work 1 Tes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cartifying Nurse Practioner: To the of my knowledge. 29b. Signature and title of certifier 29₉ License number 29d. Date signed (Month, Day, Year) o completed cause of death Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature

State

Registrar

SEP 1 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ZOWARD 2011 MONRUE Month 142 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 Ø M 2 □ F Days Min. June 2 ^{Year} 1937 Maryland 74 213-32-4632 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 🗆 Yes 2 🄀 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21403 USA 933 Edgewood Rd. Apt 107 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year of Percent Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: **Black** 3 Widowed 4 Divorced War 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Children's Hospital 12th Carpenter 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Monroe Eleanor Pinkney

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheltenham Veteran 9-15-11

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 933 Edgewood Rd. Apt 107 Annapolis, Md.

W Mame Reason SoilitSons Mortuary, P.A.

21403

21401

Approximate

20c. Location - City or Town, State

Cheltenham, Md.

23d. Date of delivery

death?

ANNAPOLI MOZIKU

1 Yes

Day

24b. Were autopsy findings available prior to completion of cause of

2 No

Month

for State Registrar

10a State

Director

Funeral

þ

Completed

Be

မ

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

20a. Method of Disposition

Amy M. Monroe(Wife)

Physician/

Medical

Examiner

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notified at

nan "natural", o Medical Exam

2 should be filed within 72. h and Mental Hygiene. 7 is marked other than "r

permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the

Baltimore, Maryland 21215-0036

Physicans Medical Examiner

and -transit

physician a s the burial-

attending p

the

signed by t

has

After this certificate

neral Director: A

that the death certificate be executed

Division of Vital Records, P.O. Box 68760

1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ERITONI disease or condition resulting in death) Due to (or as a consequence of) GANGRENOUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Exami ABFTES Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner to he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d Date signed (Month, Day, Year)

pleted cause of death (Item 23a) (Type Print)

32. Registrar's Signature

To the Hospital or Attending Physician: The law requires within 24 hours a To the Funeral D State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

1 6 2011

DEFENSE

0 21438

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			Please	Type or Prir					_	_	ble.				
			For State	State of Ma	arylan		partment of F Partificate of L		nd Mental Hy	20	110	1100			
			Registrar 1. Decedent's Name (First, Middle, Last	*)			rtincate of L	Jean	2. Date of De	Reg. No.	3. Tim	e of Death			
	Physicia Medic		Martha	E11en			Massey		Month 9	14 20	Year 011 6:3				
1	Examir		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or	r Location of D	Death	4c. County of Death					
	Funeral		7660 Parsonsburg 5. Social Security Number 6. Se		(In yrs. la	st birthday	If Under 1 Year	rsonsb I if Under 24	Hrs. 8. Date of Birt	th	9. Birthplace (Sta	te or Foreign			
	Director		411-38-5753	□ м 2 Х F	91	Yrs.	Months Days	Hours	Min. 1—21—1	920	Marylan	ıd			
	ind show at		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or L	ocation				10d. Insid	e City Limits			
	Maryla 28a-f s otified	Director	MD Wicom	ico		Sa	lisbury				1 🗆	Yes 2 ሺ No			
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at		10e. Street and Number				10f. Zip Code			10g. Citizen of WI	hat Country?				
	ath wi	Funeral	1934 Autumn Grove	Court 12. Was Decedent E	ver in U.S	3. 13.		1804 lispanic Origin	? (Specify Yes or No-	USA 14. Bace	- American Indian	<u> </u>			
9	fter de , or ite amine	þ	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 💢 I			If Yes, specify Cube 1 ☐ Yes 2 🕅 No		? (Specify Yes or No- Puerto Rican, etc.)		, White, etc.	, ,			
21215-0036	ours af	eted	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	If Yes, Give Year or Dates.		10- D.	edent's Usual Occup			Specify:					
215-	an "na Medic	Completed	(Specify only highest grades Elementary/Seconday (0-12)	de completed) College (1-4 or 5-	.)	(Give	edent's Usual Occup e kind of work done (DO NOT use retired)	during most of	working f	16b. Kind of Bus	iness Industry				
212	is filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		7	College (1-4 of 5	T)		Homemake	r		Own	n Home				
and	be filed ental H ked otl ic even	To Be	17. Father's Name (First, Middle, Last)						Name (First, Middle,	Maiden Surname)					
Maryland	12 should be filed with alth and Mental Hygien 27 is marked other ti r traumatic event, the	110	Daniel 19a. Informant's Name/Relationship (Type	pe, Print)		Masse 19b. Mai		Roxie and Number o	or Rural Route Numbe	er, City or Town, Sta	Dormar ate, Zip Code)	1			
	1 and 2 sl of Health a item 27 is other tra		Charles H. Massey	, SrHust	and	1934	Autumn G	rove C	ourt, Sal	isbury, M	iaryland	21804			
Baltimore,	ge 1 and nt of Hea : If item or other		20a. Method of Disposition 1	Removal from State	20b, P	lace of Disp emetery, cre	oosition (Name of ematory or other plac		Date		City or Town, State				
altin	permit. Page 1 a Department of I Important: If ite any injury or of		4 ☐ Donation 5 ☐ Other (Specify 21, Signature of Emeral Service License		Wic		Memorial 22. Name and Addre		9-17-2011			land			
B	permit Depar Impor any ir		1/1/1/15 TE	Signature of Emeral Service Licensee 22. Name and Address of Facility Bounds 705 E. Main Street, Salis											
П			23a. Part 1. Enter the disease, or composhock, or heart failure. List only of	cations that caused e cause on each line	the death	n. Do not er	ter the mode of dyin	ng, such as car	rdiac or respiratory ar	rrest,		Between			
F	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Carre	10 m	45 De	ethy				Onset a	ind Death			
and the same	Examiner		f	Due to (or as a	conseqq	erice ei).	/								
	p #	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	ence of,					- 14				
	executed an and rial-transit	Examine	Cause (Disease or iinjury that initiated events resulting in death) Last	c Due to (or as a	consequ	ence of):						- 1			
0		l= 1		d											
Box 68760	that the death certificate be ned by the attending physici e detached for use as the bu	Physician/Medica	IF FEMALE:												
ox 6	ath ce attend for us	cian,	in the past 12 months?	23c. If yes, outcome of 1 ☐ Live Birth 4 ☐ Pregnant at	2 🗀 Feta	l death 3	☐ Ectopic pregnand	су		23d. Date Mon	e of delivery ith Day	Year			
O. B.	the de by the ached	hysi	1 ☐ Yes 2 █ No 9 ☐ Unknown	9 🗌 Unknown											
	res that the death signed by the atte d be detached for	ρ	Part II. Other significant conditions co	ntributing to death bu	ut not resi	ulting in the	underlying cause gi	ven in Part I.	23e. Did t	obacco use contrib	bute to the cause 3 Probably 4				
ords	luoul peen	letec							24a, Was	/	ere autopsy findin				
Sec.	sician: The law requires certificate has been signirector, page 2 should be	Completed	-						auto	psy pr	rior to completion eath?	of cause of			
talF	ysician: T is certifica director, p	Be C	25. Was case referred to medical examiner?						(Check only one)	2/11/10	1 163 2 12 100	- A			
Ϋ́	Physician: this certific ral director,	: To	1 ☐ Yes 2 No 7	Hospital: 1 ☐ Inpatie 28a. Date of injur		ER/Outpati	ent 3 DOA Oth	4 ∐ Nursi	ing Home 5 Resi	dence 6 Other	(Specify)	Koyline			
o uc	Attending I er death. ector: After by the funer	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,		injury	work			now injury oceanies	f				
Division of Vital Records,	or Atte fter de lirecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc			treet, factory, office		28f. Location (City or Tov	Street and Number vn, State)	or Rural Route N	umber,			
Ō	spital o		29a. Certifier Certifying Phys	ician: To the best of	mv knowl	edge, death	occured at the time	e, date and pla	ce, and due to the ca	ause(s) and manner	r as stated.				
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 Medical Examir only one) 3 Certifying Nurs	ner: On the basis of ex	amination	and/or inve	stigation, in my opini	on, death occu	rred at the time, date a	and place, and due t	to the cause(s) and	manner stated.			
	Vith Vith Con		29b. Signature and title of certifier	DA		٨٠٨	29c. Licens	e number	70	29d. Date signed	(Month, Day, Year)			
	B		30. Name and address of person who co	ompleted cause of de	ath (Item	23a) (Type	Print)	60	18	(//	-//				
	91.		DAVINE Caux 4	ND COAST	ALL	JOSPIC	E POBO	x/73	3 SAUSB	exy, und	2180.	_			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signat	ure	1			./					
	Hegiou	al I	3EP 15.7	WII The	erd.	5.	AL S								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 State Registrar amended item 13/20-wchd-te-9@htfficate of Death 2. Date of Death 3. Time of Death Physician/ Year Linda K. Mayfield 09 2144 M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbur Kegional Medical center reninguig Wicomico If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days **Director** 218-58-0003 1 M 2 X F 60 06-20-1951 Delaware iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 X No MD Snow Hill Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1905 5 Bridges Road 21863 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: -White--"natural", 3 Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CNA **Healthcare** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev 2 Ralph Smith Beatrice Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy L. Andrie / Daughter 32095 Hazzard St., Dagsboro, DE 19939 Baltimore, 20a. Method of Disposition Place of hisposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parsekk-Funeral Homes 9/22/2011 Lewes, DE **Crematorium** 21. Signature of Funeral Service License Parsell Funeral Homes & Crematorium 34874 Atlantic Ave., Ocean View, DE 19970 Part 1. Ent the dishock, heart sese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Interval Between Onset and Death Immediat Carte (Final disease or condition Physician/ ASCUD Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Tes 2 No 3 Probably 4 Vunknown reper li pi dem 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital 2 No မ 1 Inpatient 2 KER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death. Funeral Director: After th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my olinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 450497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TO CON St. Salisbury MD 21801 ristopher 31. Date filed (Months Par Year) 6 201 State Registrar

68760

Box (

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 7:30 PM Leah Blanche Ohler 2011 Sept Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Emmitsburg 17509C Old Gettysburg Road Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 09/24/1929 Country)
. Virginia 1 □ M 2 🕱 F Min. Months Days Hours Director 218-24-9792 81 W. Usual Residence of Decedent ms 23a or 28a-f show must be notified at e filed within 72 hours after death with the Maryland tal Hygiene. and every and other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f shower, the Medical Examiner must be notified at event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 No MD Frederick Emmitsburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 17509C Old Gettysburg Road 21727 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Folder & Skiver Shoe Factory Be t. Page 1 and 2 should be filed rtment of Health and Mental Hy rtant: If item 27 is marked out njury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ada Lillian Fravel Edgar Seymour Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21727 17509C Old Gettysburg Rd. Emmitsburg, MD Eric Ohler - Son permit. Page : ____ Department of Her Important: If iter ': iny or o' 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 09/06/201 4 ☐ Donation 5 ☐ Other (Specify) Manchester, MD Faiths Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home Emmitsburg, 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) mon Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin RT The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 page 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 100 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work? 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

or Attending Physician: Division of Vital To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the

Maryland 21215-0036

Baltimore,

State Registrar

Medical

29a. Certifier

10 31. Date filed (Month

(Check

3 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23. Type, Print)

Registrar's Signatur

certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 09-06-2011

west Main SI RECK

29c License number

		Am	end # 25,27,28a	ase Type or Pri Fr. per ME go State of M	nt in E	3lack ir 729/11 d 7 Depa	n delib TRT artmen	le Ink	c. Ens lealth	ure A and N	II Copie Iental Hy	s Are	e Legibl	е.	
			State Registrar 1. Decedent's Name (First, Middle				tificate					Reg. N	711	3	1423
	Physicia Medic		James The	omes Orn	doff	2					2. Date of De	Di Di	ay 17 Yea		Time of Death 234 ам
e part	Examir	ner		Maryland			Bal	tim				40	c. County of De	eath	
	Funeral Director		5. Social Security Number 236-62-7285 Usual Residence of Decedent	6. Sex 1 X M 2 □ F	e (In yrs. Ia: 72	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 5/10/	rth 1939	g. E W	Country	State or Foreign
	faryland 3a-f show tified at	Director	10a. State 10b. County	KELEY		Town or Lo		G					-		side City Limits
	with the N 23a or 2 ust be no	Funeral Dir	10e. Street and Number 703 PORTER A	VENUE APT. 2	09	9 10f. Zip Code 2540.2			401			10g. C	Citizen of What Country?		
9800	is filed within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☑ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Von Cine		If	Vas Deced Yes, spec	ify Cubai	n, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	-	14. Race - Ar Black, WI Specify:		
Maryland 21215-0036	led within 72 hou Hygiene. other than "nat ent, the Medica	Completed by		nt's Education est grade completed) College (1-4 or 5	i+)	16a. Deced (Give I life. DO TEACI	ind of wor NOT use	k done d		t of worki	, I			ss Industry	
yland	ould be filed d Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, L JAMES HERBI	.ast) ERT ORNDOFF					18. Mothe		e (First, Middle, 'ARDIT				
	2 shouth and 27 is in traum		19a. Informant's Name/RelationsI								Rural Route Number, City or Town, State, Zip Code) INWOOD, WV 25428				
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	1 ☐ Burial 2 ☐ X cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)										City or Town, State	
Bai	permit Depar Impor any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, 327 W. KING ST., MARTINSBURG, WV 2540												21,
ال در ابستا	Inysician Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)				Inter	roximate val Between et and Death							
	sit d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a conseque	ence of):				0		17	LEXAMINER		
09	ite be executed hysician and the burial-transit		Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	a conseque	ence of):			CEP	TIFICATIO	N APPROVED B	, KEDICA	TEV		
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 🔲 Fetal	death 3 🗌	Ectopic p Other (spe		/				23d. Date of o	delivery Day	Year
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	Nithi Com		29b. Signature and title of confifier			nysicia						29d. Da	ite signed (Moi	nth, Day, Ye	
_	2			who completed cause of de	eath (Item 2	3a) (Type, Pr	int)				re, Ma	-			
	Stat Registra	e ir	31. Date filed (Month, Day Year)	32. Registra	r's Signatur	back	1								

amends Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 31424 For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death September 8. 2011 11:06 P M Myrtle B. Parenteau 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mt. Alry

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Month Day, Year | 927 Frederick Kline Hospice House Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Mary land 219-20-2559 84 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8321 Edgewood Church Road 21702 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Secretary 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Trizpee Myrtle Trittipoe Hermann B. Brust, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3225 Turtle Creek Blvd. #1545, Dallas, TX 75219 Michael A. Edwards / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/13/2011 Mt. Olivet Cemetery Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 21. Signature of Funeral Service License 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 . Enter the disease or complications that cause or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC disease or condition MONTHS resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE:

Pnysician/ Medical Examiner

Physician/

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Department of H Important: If ite any injury or oth

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Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine and -transit attending physician a for use as the burial-Be Completed by Physician/Medical the signed by page 2 certificate has မှ this Medical Certificate; s after death.

I Director: Aff
d in by the fu 24 hours a

Division of Vital Records, P.O. Box 68760

the Hospital or Attending

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23d. Date of d Month	lelivery Day	Year				
Part II. Other significant conditions cor	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.		o use contribute t		
				24a. Was an autopsy performed	prior to death?	autopsy findin completion es 2 \Begin{array}{c}	of cause of
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27. Manner of Death 1 Anatural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	jury occurred					
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	28f. Location (Street) City or Town, Sta		ural Route Nu	ımber,		
(Check 2 Medical Example)	cian: To the best of my knower: On the basis of examination	n and/or investigation, i	n my opinion, death occurre	d at the time, date and pla	ice, and due to the	e cause(s) and	I manner state

29d. Date signed (Month, Day, Year) 9-9-11

DHMH 17 Rev 7/2009

5

State Registrar

within 2

29b. Signature and title of certifier

30. Name and address a person

31. Date filed (Mosth-Day

Taimur,

TJ Drive, Frederick, MD 21702

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

46-B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 201 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 11, 2011 Physician/ James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** aurel Regional Hospital Prince George's Laure Social Security Number If Under 1 Year | If Under 24 Hrs. g, Birthplace (State or Foreign 6. Sex 1 **X** M 2 □ F 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Min. (Month, Day, Y. November 14. Months Days Hours Country) Maryland 212-06-5280 Director 42 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "marked" only or other than "marked". 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7301 Summerwind Circle 20707 United States of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Completed by 1 Yes 2 No If Yes, Give X Year or Dates. 1 Yes 2 X No Specify: SpecifAfrican American 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Debt Collector Ford Credit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William S. Phelps Nakanishi Yoshiko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Phelps (Brother) 272 Tiger Lane, Placentia, CA 92870 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 9/15/-2011 Glen Burnie, MD 21. Signature of Funeral Se vice Licensee 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ iver disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate h 1 Yes 2 X No 1 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) September 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road aurel Regional Hospital

Registrar DHMH 17 Rev 7/2009

State

Nega Ali Goji, MD 31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ricciano 6 25 am Medical 4a. Facility Name (if not institution, give street and number Examiner City, Town, or Location of Death Anne Aru 6. Sety 1 Ø M 2 □ F Funeral If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Director Months 193-14-3740 8/27/1925 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho amportant: If item 27 is marked other than "natural", or items 23a or 28a-1 sho ampointly not other transities event, the Medical Examiner must be notified at 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Crofton 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1602 Earlham Ave 21114 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 XYes 2 □ No 1944 Black, White, etc. 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed Specify: White 1946 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Naval Architect Department of the Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Picciano Nancy Yanarella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Picciano / Wife 1602 Earlham Ave., Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 4 Donation 5 Other (Specify) 9/15/2011 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home . Signature of Funcial Service Libensee 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ Immediate Cause (Final disease or condition resulting in death) Medical as a consequence of Examiner covcinama slatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Other (specify) Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has l 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 🗌 No Yes 1 Tes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending within 24 hours after death To the Funeral Director: A 2 Accident
3 Suicide Investigation 1 🗌 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Homicide determined 28f. Location (Street and Number or Rural Route Number, building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

liden Reeder		State of Maryland / Department of Hea I- For State Certificate of Deal Registrar			201	3142
Physicia Medical Examir	n/	Decedent's Name (First, Middle,Last)		ate of Death		3. Time of Death 0106 hrs
viedicai Examii	ier	Aiden Charles Reeder 4a. Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of Death	^{flonth} eptember	23, 2011 4c. County of Death	0106 nrs
		Peninsula Regional Medical Center Salis			Wicomico	
Funeral Director		214-91-3532 1XM 2F Yrs. Montl	hs Days Hours Min.		(MM/DD/YYYY) 9. Birth Foreign 9,2011	
any	ı	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show	ğ	MD Worcester Snow Hill		1		1 Yes 2 XNo
he Mary n nr 28a ified at	Director		p Code 1863	100	g. Citizen of What Count ${\sf USA}$	try?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a nr 28a-f she matter event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Yes, specific	ent of Hispanic Origin? (Specify ify Cuban, Mexican, Puerto Rica		14. Race - Americ White, etc.	an Indian, Black,
ifter des	by Fu	1 Yes 2 X No	2 ☑ No specify:		Specify: Wh	ite
hours a	ed b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual	Occupation (Give kind of work orking life. DO NOT use retired)	done	16b. Kind of Business/In	dustry
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Baltimore, MD 21215, permit. Pages I and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked of injury or rather traumatic event, the		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Communication (National Communication) 1 X Burial 2 Cremation 3 Removal from State (T1))	17	20c. Location - City or T	
altim mit. Pa partmen portant	ŀ	4 Donation 5 Other Specify: What Coat Cer 21. Signature of Funeral Service Licensee 22. Name and	metery 10-1 Address of Facility Buro		Snow Hill uneral Ho	
		108 W	illiam Stree	t Ber	lin, MD 2	1811 //
Physician /Medical		23a. Print I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.		piratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Suden unexplained death Due to (or as a consequence of):	in infancy			
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50, te be ex nysician	Medical	FFEMALE: 23c. If yes, outcome of pregnancy	e,g920 10-24-1.	ı sm	23d. Date of delivery	
687 certifica nding ph	ian/	3b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy		Month Da	ay Year
Box 6876 ne death certificate the attending phy ned for use as the?	Physician/N	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Spe	ecify)			
P.O.	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.		acco use contribute to the	
cords, P.C. law requires that has been signed I	ete			24a. Was an	24b. Were auto	opsy findings available
Vital Records, hysician: The law require this certificate has been sidirector, page 2 should be	Completed			autopsy perform 1 ✓ Yes 2	ed? death?	mpletion of cause of
Vital Rec	S B	examiner?	26.Place of Death (Check only of			
of Vi	잂	1 Yes 2 No	OOA Other Nursing Ho. 28c. Injury at Work? 28d.		esidence 6 Other:	
ttendin death. rtor: A	ation	1 Natural 5 Pending Investigation Fd 9-23-11 fd 12:30 am		known		
Divis pital nr At ours after d ceral Direct filled in by	Certification:	3 Suicide 6 X Could not be determined Specify residence	v, office building, etc. 28f.	Location (Str or Town, Sta IOW Hi	reet and Number or Rura te) 102 Powe1	Route Number, City 1 St.
	ल	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the cone 2 Medical Examiner: On the basis of examination and/or investigation, in my	e time, date and place, and due	to the cause(s) and manner as stated	
To wit	¥	29b. Signature and title of certifier	c. License number		29d, Date signed (Mont	
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		September 23, 20	717
9		Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore	Street, Baltimore, MD 2	1223		
Sta Registr	-	SEP 2 7 2011 32. Registrar's Signature.	,			
DHMH 17 Rev 1/200		DOME ORIGINAL	·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 31428 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death S Month Physician/ Day 253 M Karen Jo Reed eotember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 548-50-7462 1 M 2 X Hours Min (Month, Day, Year) -10-1938 IA Country) 73 Director Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Timber Ridge Dr. 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Electronics Assembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Thieben Agnes Miske 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 Pennsylvania Ave., Westminster, MD 21157 and 2 s Health tem 27 Debra K. Hanessian 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of F Important: If ite 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State injury South Carroll Crem 9-14-11 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home litter III donus 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami burial-transi Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ____ Pregnant at time of death g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner 🖋 Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation M Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) WIL 3946 D32 M.T) 3 PARKWAY 30. Name and address of person who completed cause of death (Jeep 23a) (Type, Print) 201

Registrar DHMH 17 Rev 7/2009

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2011 Lola M. Redmer 11:23 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4932 Wentz Road Manchester Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F (Month, Day, Year) Aug 23, 1923 Months Days Hours Min. West Virginia Director 234-24-9509 88 Aug Usual Residence of Decedent 28a-f shov items 23a or 28a-1 shoner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits **Funeral Director** Carroll Manchester 1 Tes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21102 USA 4932 Wentz Road 1 and 2 should be filed within 72 hours after death f Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Þ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally injury or other traumatic event; the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School Assistant Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Leonard Perry Alice Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Preston, daughter 2737 Mt. Ventus Road, Manchester, MD 21102 20a. Method of Disposition 20b. Place of Disposition (Name of A cemeter action) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/8/2011 Manchester, MD Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liperise 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of cate has I autopsy performed Yes 2 death? 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 \(\sum \) Yes 2 \(\sum \) No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Definition of the best of my knowledge, death occurred at the time, date and place, and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Definition of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat ire and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER, MD. 555 S. CENTER FLAU10 ST 21157 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

SEP 0.8 2011

Box 68760

P.O.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9 1828 F M CHARLES E. RADECKE SOI! Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death . 4456414 NICOMICO MONDL Social Security Numbe Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F NY ountry) 218-34-8265 May 31, 1917 Yrs **Director** Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f shorexaminer must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Delmar MD 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21875 605 E. Pine Street 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc by 1 Never Married 2 Married Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afti.
Department of Heatilt and Mehralt Hygien important. If item 27 is marked other than "natural", important. If item 27 is marked other than "any injury or other traumatic event, the Medical Exat 1 ☐ Yes 2 🙀 No Specify Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tractors Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Radecke Lydia Franke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4416 Coulbourn Rd, Salisbury, MD 21804 Ronald Peterman/step-grandson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 09/15/2011 Mardela Springs,MD Mardela Memorial Cem: 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee . Name and Address of Facilit Short Funeral Home, 13 E.Grove St, Delmar, DE 1994 Part 1. Enter the disease, or complications shock, or heart failure. List only one cause ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) ō in the past 12 months? Day Year Pregnant at time of death 2 No ed by the a detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Vnknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed?

1 Yes 2 No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: မှ 1 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral C Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29c. License number 29d. Date signed (Month. Day, Year, . Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 100 E

		1- For State Registrar	ate of Maryland	•	rtificate of		u ivientai	, ,	eg. No.	1 3143		
Physic Medical Exam		Decedent's Name (First, Middle)						2. Date of Dea	ith	3. Time of Death		
viedicai Exam	ıneı	Odessa Louise I 4a. Facility Name (if not institution		r)		4b. City, Town, or	Location of Do	Septembe	Day Year er 15, 2011 4c. County of Dea	1052 hrs		
<i>)</i>		Atlantic General Hosp		17		Berlin	Location of De	auı	Worcester	tn		
Funeral Director		5. Social Security Number 213–86–5631	6. Sex 7. A	ge (In yrs. I	last birthday) Yrs	If Under 1 Year Months Days		1in.	th (MM/DD/YYYY) 9. B Fore 3, 1963	irthplace (State or ign ountry) MD		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Locati	on				10d. Inside City Limits		
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with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 10604 Flower St	reet			10f. Zip Code 21811	<u> </u>	1	0g. Citizen of What Coo USA	untry?		
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Marnal Hygiend teath and Marmal Hygiend than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral				If Y	s Decedent of His es, specify Cuban	, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Race - Ame White, etc.	rican Indian, Black, Erican—		
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Baltimore, permit. Pages 1 at Department of He Important: If ite		21. Signature of Funeral Service I	Licensee					uneral H	OME DA	10		
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/Medical Examiner		failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)		Between Onset and Death								
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of	F)·							
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of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed when this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - trans	Completed	<u>Diabtes Mellit</u>	us,Chronic	Alcoh	olism,M	orbid Obe	esity	24a. Was a autops perfor	sy prior to one death?	utopsy findings available completion of cause of		
Vital Registration in the confidence director, page	æ	25. Was case referred to medical examiner?	Hospital:		FD/0		of Death (Check					
of Vi ing Physi After this funeral dir	<u>ا</u>	1 V Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,Y		ER/Outpatient 28b. Time of Inj			ing Home 5 1 28d. Describe h	Residence 6 Othe			
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Division of V To the Hospital or Attending Physical Willing 24 hours a or death To the Funeral Livector: After this completely filled in by the funeral disconnected of the funeral disconnected or th	Certification:											
To the Ho within 24 Fo the Fu	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	2	29b. Signature and title of certifier	11 K. 0	TA)	29c. License O.C.M	- now	0 10 10	29d. Date signed (Mo. September 16, 2			
-		30. Name and address of person w Theodore M. King, Jr.,			,	00 W Raltime	re Street	Baltimore, MD	21223			
Sta Regist		31. Date filed (Month, Day, Year)	- A/			J. Daitini	Jueet, t					

ORIGINAL

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To the Hospital or Attending Physician; The law requires that the death certificate bewithin 24 hours after death. To the 124 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burners.	Physician/Medica			d										
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or Att after d Directo in by t	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could determ				treet, factory	office		28f. Location (City or To			ıral Route Number,	
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in 24 h	Medical	(Check 2	Medical E	xaminer: On the basis of e	xamination	and/or inv	estigation, in a	my opinion	n, death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner st	ated
Nith Con To the		29b. Signature and t	title of certifier	क रा	EINE	> : + < c	290	. License	number	160	_	ate signed (Mont		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 31433 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ good! CLYDE W. SCHAFER 925 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Peninsula Regional Medical Salisburi WICOMICO center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 212-34-5900 75 1 **X** M 2 □ F 9/27/1935 Maryland Usual Residence of Decedent 28a-f show the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** be notified Florida Charlotte Punta Gorda 1 🗌 Yes 2 🔀 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Page 1 and 2 should be filed within 72 hours after death with 3517 Peace River Drive 33983 USA items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 27 is marked other than "natural", or i traumatic event, the Medical Examin by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) General Motors 12 <u>Material Supervisor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ Warren Schafer Mary Jane Owings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Mary L. Schafer (Wife) 103 Williams Street - Unit 115 - Crisfield, MD 21817 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 9/20/2011 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BRADSHAW & SON Wain St. - Crisfield 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main St. - Crisfield, MD 21817 Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, it may be a sequentially list conditions cause. Enter Underlying Examine Dusité (dr es a consequence de) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran and Due to (or as a consequence of): attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation Suicide 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 31 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

XCA

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State

Name and address of person who completed cause of death (item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31434 State Registrar #5. Certificate of Death per fh, 9/26/11, ca 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9-Physician/ 20 9:20PM LENA CATHERINE SNEADE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Hospice at the Sal Lake 15 bury 8. Date of Birth (Month, Day, Feb. 26, If Under 1 Year 7. Age (In yrs. last birthday) If Lind≽r 9. Birthplace (State or Foreign Funeral 0-01-9708 1 M 2 X F Days Min. Hours Mary Land Director 98 Jsual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location Director Examiner must be notified 1 Yes 2X No Maryland Somerset Rhodes Point 9 10e. Street and Numbe 10g. Citizen of What Country? items 23a Funeral 3395 Marsh Road 21824 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XXXVo If Yes, Give 1 ☐ Yes 2X No Specify: White "natural", Specify 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ပ္ Levin Waters Marsh Nellie Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Evans (Daughter) 101 Tracey Circle - Laurel, DE 19956 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Calvary Church Cemetery 9/16/2011 Rhodes Point, Maryland 4 ☐ Donation 5 ☐ Other (Specify) mary Beth Bradshaw 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARIDIOMYOPA disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 ası IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Day Pregnant at time of death Linknown 9 Unkrown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown has been signed 2 should b Completed 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an autops prior to completion of cause of death? Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: HOSPI CAZ မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, pleted filled in by 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. etifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) ss of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 15 2011 HATTIE MARIE CONNER SMITH 1:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death QUEEN ANNE'S CORSICA HILLS NURSING HOME CENTREVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday, 8. Date of Birth **Funeral** Months Days Hours Min. **Director** 88 10/30/1922 VĬŘĠĬNIA 236-22-8238 Usual Residence of Decedent 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 🗶 Yes 2 🗌 No MD QUEEN ANNE'S CENTREVILLE 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? Ith and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be I Funeral 205 ARMSTRONG AVENUE UNITED STATES 21617 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Page 1 and 2 should be filed within 72 hours after þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify 3 X Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 SCHOOL BUS DRIVER TRANSPORTATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ROSS CONNER FANNIE HELMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. JONATHAN SMITH/ SON 244 HERITAGE WAY, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION 09/16/2011 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Approximate Interval Between Onser and Death Immediate Cause (Final Ph_sician/ disease or condition 7 1 Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami burial-transit Cause (Disease or in that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death signed by the aid be detached for 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an has prior to completion of cause of death? perforn certificate 2 No 1 Yes To the Hospital or Attending Physician: æ 25. Was case referred to medical 26. Place of Death (Check only one) 2 Hospital Other ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) the Funeral Director: After this upleted filled in by the funeral di Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending injury after death Accident 1 Yes 2 No Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier etrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the comple Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a

State

Registrar

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Registrar's Signature

ho completed cause of death (Item 23a) (Type, Print) 2/08 0.

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Year Month 5:37PM PONO Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Country) 1 M 2 X F Y0722/1922 215-12-3997 Vrs MD Director 88 Usual Residence of Decedent 28a-f shov 10a. State 10b County 10d. Inside City Limits with the Maryland notified at 10c. City, Town or Location Director 1 Yes 2 □ No MD Carroll Westminster 10e Street and Number 0 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be Funeral 43 Timber Ridge Drive USA 21157 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceud... Armed Forces? 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) American Hammer 10 Laborer of Health and Mental Hygie item 27 is marked other other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental fitem 27 is marked George Franklin Moss, Sr. Annie Murray 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Storey/son 697 S. Springdale Road, New Windsor, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State - 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Page 1 _ ხ Department of Important: If any injury or 109/12/2011 Carroll Cremation |Hampstead, MD 22. Name and Address of Facility Pritts Funeral Home & Chapel Signature of Funeral Service Licensee 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a or requence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to a r as a conseque e of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent prednant 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Day 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes . Were autopsy findings available prior to completion of cause of death? 24a. Was an the Funeral Director: After this certificate has appleted filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) =) J. Valo, M.D 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

Patient known as Chad Shaffer
Baltimore, Maryland 21215-0036

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Chad Shaff 11:24 PM UGUST 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore OF HOSPital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) (Month, Day, Year) ay 31, 1977 1 ★M 2 □ F Days Hours Min Maryland 219-17-4483 34 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified PA Adams Littlestown · 28a-f 1 X Yes 2 ☐ No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States must be by Funeral 23a 140 Apple Grove Lane 17340 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc 6 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) food distributor route salesman/supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Betty A. Caldwell should be file τ and Mental Η γ is marked ot မ Chester A. Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo JoEllen L. Shaffer / wife 140 Apple Grove Lane Littlestown, PA 17340 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Sept. Hampstead, Maryland Carroll Cremation 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Lice 22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074 M01072 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ gastrointestinal bleed Acute day disease or condition Medical resulting in death) Examiner adenocarcinoma of Esophagus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as I the attending parties as the distribution of the attending parties as the attending parties as the attending parties as the attending parties as the attending parties as the attending parties as the attending parties as the attending parties as the attending parties as the attending parties as the attending parties are attending parties as the attending parties are attending parties as the attending parties are attending parties as the attending parties are attending parties as the attending parties are attending parties as the attending parties are attending parties are attending parties as the attending parties are attending parties as the attending parties are attending parties and attending parties are attending parties and attending parties are attending parties and attending parties are attending parties and attending parties are attending parties and attending parties are attending parties and attending parties are attending parties and attending parties are attending parties and attending parties are attending parties at a second parties at a second parties are attending parties at a second parties at IF FEMALE: 23c. If yes, outcome of pregnancy

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4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day signed by the a d be detached f 2 No _ Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia 2 No Completed 3 Probably 4 Unknown peen Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural injury 5 Pending work? 1 Yes 2 No Accident M Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number RES-000 ss of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave. Baltimore, MD 21215 PRIYANKA SINAI HOSPITAL YER MBBS 31. Date filed (Month, Day, Year) SEP 0 6 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Reg. No. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 6:24 A M Starliper 2011 SEP Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 577-24-6801 1 □ M 2 😾 F Director 89 MD 7/28/1922 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location the Maryland at ed other than "natural", or items 23a or 28a-f si event, the Medical Examiner must be notified 1 X Yes 2 No Silver Spring Prince George's Maryland ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. Apt. 512 3152 Gracefield Road 20904 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify: 3 👿 Widowed 4 🗌 Divorced white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event "to once." Elementary/Secondary (0-12) College (1-4 or 5+) Document Management Executive Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy M. Inscoe Eugene H. Allison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2406 Basenores Mill Rd., Westminster, MD 21158 Dennis A. Starliper / son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 9/17/2011 Laurel, MD Ivy Hill 22. Name and Address of Facility Fleck Funeral Home, Inc. Signature of 7601 Sandy Spring Rd, Laurel, MD 20707 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CAP Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 X No
9 Unknown Month Year Day 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown certificate has been signector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? HTN autopsy performed? Yes 2 V No 1 Tes 2 😾 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No 1X Inpatient 2 ER/Outpatient 3 DOA ည 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending s after death.

I Director: Aft Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Hospital Medical 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Lona

State Registrar ANNA

31. Date filed (Month, Day, Year)

GRACEFIELD

3110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Régistrar's Signature

KORZAN

SEP 1 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ State	aryland / Depa	artment of H			20	11 31439		
		1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)	Oei	incate of L	, catii	2. Date of Dea		3. Time of Death		
Physici Medi		Norma Lee Sabonis			<u></u>	Septemb	er 19	2011 9:30 a ^M		
Exami	ner	4a. Facility Name (if not institution, give street and number) Harmony Hall		**	Location of Death			4c. County of Death Howard		
Funeral	г	5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h	9. Birthplace (State or Foreign		
Director		578-46-4547 Usual Residence of Decedent	76 Yrs.	Worldis Days	Hours IVIIII.	12/31/		Wash, DC		
land show d at	ţo	10a. State 10b. County	10c. City, Town or Loc	cation		1 / /		10d. Inside City Limits		
e Mary 28a-f notifie	irec	MD Howard	Colu					1 ☐ Yes 2 🏖 No		
with the	Funeral Director	10e. Street and Number 6336 Cedar Lane		10f. Zip Code 21 0)44		10g. Citizen of United	What Country? States		
Nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 12. Was Decedent E Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spen. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac	ce - American Indian,		
336 s after al", or	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates.	No	☐ Yes 2X No		,,	Specify	ck, White, etc. White		
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupa		ina	16b. Kind of B	Business/Industry		
thin 72	Som	Elementary/Secondary (0-12) College (1-4 or 5	+) life. DO	omemaker	aring most or work	,,,,g	Ow	n Home		
nd 2	Be	17. Father's Name (First, Middle, Last)	11	CHETRACE	18. Mother's Nam	e (First, Middle,				
ylar	2	Frederick Hosley Sigmon,	Sr.		Wilma	Winifre	d Bodki:	n		
Mar 2 shou th and 17 is m traum	2	19a. Informant's Name/Relationship (Type, Print) Donna Binaut - Daughter	100	g Address (Street a						
Te, 1 and of Heal item 2		20a. Method of Disposition	20b. Place of Dispos	sition (Name of		Date		, MD 21042 - City or Town, State		
imo Page ment c ant: If ury or		1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Ardent C	natory or other place rematory		0/2011	Hano	ver, MD		
Baltimore, M. permit. Page 1 and 2 sl Department of Health a Important: If item 27 i any injury or other tra		21. Signature of Funeral Service Licensee						Family F.H.Inc. City, MD 21043		
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente					Approximate Interval Between		
Phy it i⊾n Medical		Immediate Cause (Final disease or condition resulting in death) Demen						Onset and Death		
Examiner	1	Due to (or as a	a consequence of):							
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recuter and al-trans	Examiner	Cause (Disease or injury that initiated events c	a consequence of):							
68760 certificate be executed nding physician and use as the burial-transit	dical	d								
6876 ertificat iding ph		IF FEMALE:								
Box 687(death certificat he attending ph ned for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 23c. If yes, outcome to 1 ☐ Live Birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)	У			ate of delivery onth Day Year		
the d the d by the	hysi	g ☐ Unknown								
es that the signed by the deta	þ	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.			tribute to the cause of death? 3 Probably 4 Unknown		
ords, requires been sig	letec					24a. Was a		Were autopsy findings available		
/ital Reco sician: The law i certificate has t	Completed					autop perfor	rmed?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
Vital ysician: s certifical	Be	25. Was case referred to medical examiner?			ice of Death (Chec.			Assisted		
n of Viding Physich. After this of funeral displayments	e: 10	27. Manner of Death 1 Inpatie 28a. Date of injur	ent 2 ER/Outpatien y 28b. Time of	t 3 DOA Othe	4 ☐ Nursing Ho	ome 5 Resid		er (Specify)		
on on ending eath.	ficat	1 Natural 5 Pending (Month, Day 2 Accident Investigation	; Year) injury	M 1 🗆	? Yes 2 🗆 No					
Division of Vital Records, Hospital or Attending Physician: The law requires 24 hours after death. Funeral Director: After this certificate has been sign etely filled in by the funeral director, page 2 should be	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	et, factory, office		28f. Location (S City or Tow		er or Rural Route Number,		
To the Hospital within 24 hours a To the Funeral C	Medical	29a. Certifier (Check 2 Medical Examiner Qn the basis of ex	camination and/or investi	igation, in my opinio	n, death occurred a	t the time, date a	nd place, and du	e to the cause(s) and manner stated.		
To the I within 2 To the I сотрlе	ž	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of confirm	best of my knowledge,	death occurred at the 29c. License				manner as stated. d (Month, Day, Year)		
		(m)			47447		Sep	tember 19, 2011		
4		30. Name and address of person who completed cause of de Andy Lazris, MD 6334 C	eath (Item 23a) (Type, P edar Lane		olumbia,	MD 210	44			
Sta Registr	te ar	31. Date filed (Month Ser Year 0 2011 32. Agistra	r's Signature	ake						

11-07042

Darryl Strothman		State of Maryland / Departn	nent of Health and Menta		2011	3144
Physicia Tical Examin	n/	Registrar 1. Decedent's Name (First, Middle,Last)	cate of Death	Date of Death Month	Day Year	3. Time of Death
ical Examin	ier	Daryl Romain Strothman 4a. Facility Name (if not institution, give street and number) Penninsula Regional Medical Center	4b. City, Town, or Location of Salisbury	September	4c. County of Death Wicomico	1808 hrs
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bi 357-56-5894 1 M 2 F 53 Usual Residence of Decedent	rthday) If Under 1 Year If Under Months Days Hours	24Hrs. 8. Date of Birth Min. 09 20	(MM/DD/YYYY) 9. Birt Foreig Cou	
uyland sa-f show any it once.	ctor	10a. State		I 10	g. Citizen of What Cour	10d. Inside City Limits 1 Yes 2 X No
215-0036 be filed within 72 hours after death with the Maryland mai Hygiene. riced other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Funeral Director	35352 Mt. Herman Rd. 11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	21850 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No-	USA 14. Race - Americ White, etc.	can Indian, Black,
5-0036 Hild within 72 hours after Hygien other than "natural", the Medical Examiner.	Completed by I	Elementary/Secondary (0-12) College (1-4 or 5+)	1 Yes 2 No specify: Decedent's Usual Occupation (Give kinduring most of working life. DO NOT usual December 1.	nd of work done se retired)	Specify: Whit	ndustry
21215-0036 Juld be filed within 7 Mental Hygiene marked other than e event, the Medica	8	17. Father's Name (First, Middle, Last) William Melvin Strothman	Norak	Name (First, Middle, Mone) Pell Brace		
mad 2 sho eath and 2 sho tem 27 is	ို	Bonnie Ennis 20a. Method of Disposition 20b. Place	30075 Haymarket Co of Disposition (Name of cemetery,			304
Baltimore, permit. Pages 1 an Department of He. Important: If it injury or other tr		T Durial 2 Cremation 3 - Removal nom state	sbury Crematory 22. Name and Address of Facility	' ' '	Salisbury, uneral Home	
Physician	\dashv	Keith R. Downey per dvr 23a. Part I. Enter the disease, or complications that caused the death. Do r	501 Snow Hill Ro	d., Salisbu	ry, MD, 218	304 Approximate Interva
/Medical Examiner	ical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Atherosclerotic Due to (or as a consequence of): Due to (or as a consequence of):	Cardiovascular Dis	sease		Between Onset and Death
be executed ician and irial - transit	dical	x UNPENDED x AMENDED 23a,27 pc	er me 21 per fh g9	20 10-5-11	vt	
Box 68760, c death certificate be the attending physicial of for use as the burian		Drognant at time of death		eregnancy	23d. Date of delivery Month D	ay Year
P.O. res that the signed by be detached	히	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part	1 Yes	acco use contribute to t	ably 4 🗹 Unknown
Records: The law require ficate has been so page 2 should	Completed	_		24a. Was ar autopsy perform 1 Yes 2	y prior to co ned? death?	opsy findings available ompletion of cause of S
n of Vital Recting Physician: The After this certificate funeral director, page	: 10 Be	Tes 2 No	26.Place of Death (Coutpatient 3 DOA Other 1 Time of Injury 28c. Injury at Work?	Nursing Home 5 R	residence 6 Other:	
Division of Vital Records To the Hospital or Attending Physician: The law requivithin 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	Certification	2 Accident Pending	1 Yes 2 N		reet and Number or Rur tte)	al Route Number, City
To the Hos within 24 h To the Fun completely	edical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier		rred at the time, date ar		cause(s)
		will.	O.C.M.E.		September 19, 20	
		Name and address of person who completed cause of death (Item 23a) Ling Li, MD	Baltimore Street, Baltimore, MI	D 21223		
Stat		31. Date filed (Month, Day, Year) 32. Kegistrar's Signature	back			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death September 27, 2011 Physician/ Joanna Adlington Urner Smith 2:05 PMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick **Examiner** 414 Schley Avenue Frederick Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 215-20-7731 Days Hours 87 Director 1 □ M 2 🔀 F Feb. 22, 1924 Maryland ms 23a or 28a-f show must be notified at illed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 414 Schley Avenue U.S.A. ural", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Walker Urner Irma Adlington Bradshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Schley Avenue, Frederick, MD 21702 Gerald H. Smith, husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery Oct. 1, 2011 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Frederick, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lions Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 bations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease, or compli shock, or heart failure. List only on Interval Between Immediate Cause (Final set and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 1 Hospital Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Besidence 6 ☐ Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year, September 28, 2011

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

Projection Company Company (Company Company Co	tephen Tracey	′	State of Maryland / Department of 1-For State Registrar	r Health and Mental	Hygiene Reg.		1 31442			
Substitution County Coun		1. Decedent's Name (First, Middle,Last) Stephen David Tracey 2. Date of Death Month Day Year September 25, 2011 3. Time of September 25, 2011								
212-02-5857 DN 2 29		18902 Vernon Road White Hall Baltimore County								
MD BLILINGTE Black MD BLILINGTE Hampstead 107.79.00			212-02-5857 _{13M 2 F} 29 Yrs	Months Days Hours I	Min	Fore	eign			
23. Part I centre the diseased, or complications that causes the death, Do not online the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. **MULTIPLE Injuries** **Due to (or as a consequence of): Due to (or as a consequence of):	B	Be Completed by Funeral	10a. State 10b. County 10c. City, Town or Location Hampstead 10f. Zip Code 10g. Citizen of What C USA 10g. Street and Number 10g. Citizen of What C USA 10g. Citizen of North USA 10g. Citizen of North							
The few of the first of the few o	Physician `/Medical ≟xaminer	ical Examiner	21. Signature of Funeral Service Licensee M0 0 7 4 1 22. N 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ame and Address of Facility 3.4 S. Main St ne mode of dying, such as cardia	Eline F	uneral I	HOME D 21074 Approximate Interval Between Onset and			
29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) September 25, 2011 30. Name and address of person who completed cause of death (Nem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State Registrar 31. Date filed (Month, Day, Year) SEP 2 6 2011 32. Registrar's Signature	AMENDED 23a, 21, 28a-I per me gy2U IU-5-II VE Specific and a part of the part of the past 12 months? Amended 23c. If yes, outcome of pregnancy 1						Day Year o the cause of death? obably 4 Unknown utopsy findings available completion of cause of			
State 31. Date filed (Month, Day, Year) 32. Redistrar's Signature Registrar SEP 2 6 2011 Surve A. Same	WJL	Certification: To	1							
▼					Datamore, MD 2	. 1220				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Nona Rae Jane Vanhoose September 2011 5:36 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Westminster **Examiner** 4c. County of Death Carroll County Carroll Hospital Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 X F 551-74-1267 63 Director Yrs 1948 Feb. California Usual Residence of Decedent 28a-f shov 10a. State 10b. County death with the Maryland notified at Director 10c. City. Town or Location 10d. Inside City Limits Carroll County Hampstead Maryland 1 🎇 Yes 2 □ No 10f. Zip Code 21074 ō 10e Street and Number 10g. Citizen of What Country? "natural", or items 23a or Funeral 1211 North Main Street United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 2 should be filed within 72 hours after the and Mental Hygiene.
27 is marked other than "natural", or traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) warehouse worker manufacturing 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Florence Winne Smith Raymond Burris ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Jacques / daughter Hampstead, Maryland 21074 2119 Sterling Court 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept. 6, ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation Hampstead, Maryland 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Inset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence f) Examiner Sequentially list conditions. Examiner if any, feading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonari 1 Yes Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an page 2 s has autopsy performed? Yes 2 No prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation М 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year) 36 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

D. Alexander Rocha, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

4231 Northwoods Trail Hampstead, Maryland 21074

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 334 M MICHAEL WAYNE WALKER entember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** wicomico Salisbur Peninsula Regional Medical Conter If Under If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) 10/26/1953 218-64-5009 Director 1**X** M 2 □ F Maryland 57 Usual Residence of Deceden 28a-f show 10d, Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director ems 23a or 28a-f sh r must be notified a Maryland Wicomico Bivalve 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21199 Bivalve Lodge Road 21814 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2X No ō þ 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 White nan "natural", Medical Exan If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry should be filed with...
th and Mental Hygiene.
27 is marked other than "r-----atic event, the Mer (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pepsi Bottling Venture\$ Express Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 R. P. Walker other traumatic Kathleen Mae James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s it of Health a : If item 27 i 17403 Brian Walker (Son) 1331 Hill Street - York, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If ii any injury or o cemetery, crematory or other place) ☐ Burial 2 【*Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 09/19/2011 Delmar, DE 21. Signature of the fall Source Livens of Robert H. Bradshaw, 22. Name and Address of Facility Fradshaw & Sons Funeral Home 306 W. Main St.-Crisfield, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ CARCINOMA WITH UNKNOWN PRIMARY disease or condition resulting in death) Medical Examiner DISSEMINATED INTRAVASCULAR COAGULATION (DIC) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Pregnant at time of death signed by the at Id be detached f 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has 1 Yes 2 No certificate or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 09/16/2011 272248

DHMH 17 Rev 06-2011

State

Registrar

100 E. Correil St

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Singh

SEP 2 0 2011

Kahulkumar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month C Vietta Ward - Collins 1445 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ALCOMICO MEDICAL REGIONOL 344/36UCU 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖫 F Days Director 214-34-7306 72 Maryland Usual Residence of Decedent 28a-f show and Mantal Hygiene. Is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Crisfield Somerset 1 X Yes 2 No Muryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 310 21817 11/es-U.S.A be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Black Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seafood Industr th grade abover Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Bundick Caroline Ward George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trac Cristie ld Burton Ward Sr. 310 Ty 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 17/11 MD 4 Donation 5 Other (Specify) Howwell J.Mr. Cometer f Faneral Service Licensee 21. Signature 22. Name and Address of Facility Anthony Princess Anne, MD, 2,855) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 1 Yes 2 No Yes the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 4 No 1 🗂 npatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 V Natural injury work? 2 No Accident Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year) D60515 s of person who completed cause of death (Item 23a) (Type, Print) SHOPE DR. SALISBURY MD 21864 910 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 THOMAS EDWARD 9:50A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Months Min. Hours 03/04/1935 Director 215-34-4060 76 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗷 No Frederick New Market 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21774 10811 Old National Pike 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", If Yes, Give 3 X Widowed 4 ☐ Divorced res, Give Year or Dates, 1957-60 Specify: White or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12construction contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Arthur Wiles Margaret Waltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Darlene Burall/daughter 10042 Old National Pike, Ijamsville, MD 21754 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Resthaven Mem. Gar. 09/15/2011 Frederick, MD 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Like only one cause on each line. Onset and Death MONTHS TO YEAR Immediate Cause (Final Physician/ METASTATIC LUNG CARCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes 25. Was case referred to medical Be completed filled in by the funeral director, 26. Place of Death (Check only one) 2 No Other: 은 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No s after death. 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

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Registrar

Rona

miller

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Box 68760

P.O.

Records,

of Vital

Division

mt. Airy, MD 21771

POBOX 210

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N. 20 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 7:30 PM Sept 2011 Robert June Wetzel Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick 8622 Hornet's Nest Road Emmitsburg If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 - F 68 Months Days Hours (Month, Day, Year) une 3, 1943 Mary Land Director 214-36-1390 June Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic area. 10a State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director Emmitsburg Maryland Frederick 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 8622 Hornet's Nest Road 21727 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Trash Removal Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Hattie Eyler Charles Russell Wetzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8622 Hornet's Nest Road, Emmitsburg, MD 21727 Nancy N. Wetzel, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/14/2011 Emmitsburg, MD Emmitsburg Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home Signature of Funeral Service Licensee tan 210 W Main St, Emmitsburg, MD 21727 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate
Interval Between
Onset and Death
(7)((+c 9)((1)) Immediate Cause (Final Physician/ creatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as t IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Year 4 Pregnant at time of death g Unknown 2 No ed by the a detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? as been signed ! 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed? 2 DAG 2 1 1 Yes Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: ြုင 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Kesidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury Natural 5 Pending s after death.

I Director: Af Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Funeral D Hospital Medical 29a. Certifier 🗅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 20064542 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 OPay 20T1 Harry Edward Whitworth 6:20 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Carroll Lutheran Village Healthcare Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 6 Sex Age (In vrs. last birthday) 8 Date of Birth **Funeral** Days **1**√2 M 2 □ 80 0972271930 Director 213-28-4676 Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland must be notified at Director 1 Yes 2 No MD Carroll Hampstead ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2319 Harvey Gummel Road 21074 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian, Examiner "natural", or 1X Never Married 2 Married Completed by 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Bassett Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Whitworth Virginia Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a tem 27 in tem 27 in other tra Karen Weiner/niece 2319 Harvey Gummel Road, Hampstead, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 09/07/2011 Randallstown, MD Paran Cemetery 22. Name and Address of Facility Pritts Funeral Home and Chapel 21. Signature of Faneral Service Licensee ach 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause of each line. nter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of D ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month John Leo Winner Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number Birthplace (State or Foreign Country) Maryland Sex 1 M 2 F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Days Hours Min (Month Day Year) 1938 215-36-9107 73 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f Allegany Lonaconing Maryland 1 XYes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 61 East Main Street 21539 **USA** ral", or items ? Examiner mus death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 be filed within 72 hours after 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Town Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vernard Winner Kathleen Rafferty t. Page 1 and 2 should be rtment of Health and Men rtant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 61 East Main Street, Lonaconing, Maryland, 21539 Anne Perry Winner - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State DSentember | 1 Burial 2 Cremation 3 Removal from State St. Mary's Catholic Cemetery Lonaconing, Maryland 28, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Lonaconing, MD 21539 8 East Main Street 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do nother the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ma ceers Physician/ M disease or condition Medical resulting in death) o (oi a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine onsequence of): and Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death 2 No the 9 Unknown 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death. autopsy performed 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1. Yes Hospital 2 NO Other: After this c ည 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 2 Accident 111 6,00 P 1 Tyes Investigation 161 BY To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Numb City or Town, State) determined building, etc. (Specify) 6 5 Medical Certifier: Phylician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medit | Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifier: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Within 2 29b. Signature ar title of ce 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2502 Willaward Road State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 1 Physician/ DHIRLEY Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Seasons Hospice Randallstown If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Min Months Hours **Director** 215-34-0902 1 ☐ M 2**X** F 72 Yrs. 27, 1939 North Carolina Feb. 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD Baltimore Halethorpe 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2365 Research Avenue 21227 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes XX No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Beautician Cosmotology 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard Sparks Auba Brewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Horsey-Daughter 2365 Research Drive Halethorpe Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Crownsville Veteran Cem Sept.30,2011 Crownsville MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne Signature of Funeral Service Licensee atur 2719 Hammonds Ferry Road Lansdowne Maryland 2122 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons a uence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and the burial-trai Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to hours after death. Division of Vital Records, P.O. Box 68760 88 signed by the attending d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 **N**o မ 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this r of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Acciden
3 Suicide Accident Investigation Μ 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Pragitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

State Registrar PHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Septembe 12:1000 James Earl Alston 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore Social Security Number 6 Sex If Under 1 Year 7. Age (In yrs. last birthday **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 D F Hours 5/24/1948 Director 63 212-46-3410 MD Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 X Yes 2 No MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3508 Cliftmont Ave. 2nd Fl. 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc δ 1 X Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 Specify: Black should be filed within 72 hours afte and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Morgan St. Univ. 12th Chef 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnarne) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Willie Lee Alston Anna Frances Hogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5464 Whitwood Rd. Baltimore, MD 21206 Francine Ball-Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕱 Burial 2 🗆 Cremation 3 🗀 Removal from State Memorial Pk. 10/4/2011 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Medical Onset and Death Aspiration disease or condition resulting in death) Due to (or as a consequence of): Examiner Altered 2 weeks Mental Sequentially list conditions, Examine trany leading to in redict cause. Enter Underlying Cause (Disease or linjury Decon di tionin Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical HIV Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown Pregnant at time of death 1 Yes 2 9 Unknown 2 No the been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: မ 1 ☐ Yes 2 No 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Investigation 1 Yes 2 No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State of Maryland / D			nental Hy	giene		
				Certificate of L	Death	2. Date of Dea	Reg. N.	31452	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) June Beryl Anderson	oer 30, 201	3. Time of Death 7:39 P M				
	Examir		4a. Facility Name (if not institution, give street and number)		4c. County of Death				
-			4113 Queen Mary Drive	Olney			Montgome		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Yrs.	Hours Min.	8. Date of Bird (Month, Da June 4,	y, Year)	Sirthplace (State or Foreign Country)	
	d t tow	L	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Leastian		pune 4,	1732 111	10d. Inside City Limits	
	Aarylan 8a-f sh tified a	Director	Maryland Montgomery Olney	or Location				1 🗆 Yes 2 🛣 No	
	the had a or 2 be no	Ē	10e. Street and Number	10f. Zip Code			10g. Citizen of What (Country?	
	h with	Funeral	4113 Queen Mary Drive	20832			United Sta	tes	
36	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates,	13. Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 X No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: Wh		
9-0	hours natura lical E	lete	15. Decedent's Education 16a. I	Decedent's Usual Occup			16b. Kind of Busines	ss/Industry	
Maryland 21215-0036	hin 72 ne. than "l	omp	Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done of life. DO NOT use retired)	during most of work	ing		·	
121	led within 'Hygiene. other thar ent, the M	ம	12 Se	cretary	18. Mother's Nam	- /Final Adiabata	Banking		
and	if and 2 should be filed of Health and Mental Hy fitem 27 is marked oth rother traumatic event	70 E	Alfred Bebbington		Doris Ha	, ,	Maiden Surname)		
ary	should and N is ma			Mailing Address (Street a	and Number or Rura	al Route Numbe	r, City or Town, State, 2	Zip Code)	
	nd 2 sealth m 27			16 Wendy Co	urt, Monr	ovia, N	Maryland 21	770	
altimore,	ge ta nt of H : If ite or oth		1 Burial 2 Cremation 3 Removal from State Months en	Disposition (Name of crematory or other place	ce) Octo	pate 3,	20c. Location - City		
Itim	permit. Page . Department o Important: If any injury or any injury or once.		4 □ Donation 5 □ Other (Specify) Cremato	orium, Inc.	20:		Bethesda,		
Ba	permit. Page 1 ar Department of He Important: If iter any injury or oth		Hara 11. Charlon MO1530	300 W. Mont	tgomery A	ve., Ro	<u>ckville, M</u>	kville, Inc. aryland 20850	
	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End Stage Renal	Disease	g, such as cardiac (or respiratory an	rest,	Approximate Interval Between Onset and Death 4 Years	
die	Examiner		Due to (or as a consequence of Hypertension	η):				Years	
-		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	f):				lears	
36	cuted ind transit	Examiner	Cause (Disease or injury that initiated events c.						
	ate be executed physician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of	.):					
760	cate to	ledic	d						
Box 687	death certificate be executed attending physician and ed for use as the burial-transi	M/ng	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death	3	21/		23d. Date of c	delivery	
Bo	requires that the death certifice been signed by the attending p should be detached for use as	Physician/Me	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{SNO} \) 9 \(\text{Unknown} \) 9 \(\text{Unknown} \)	5 Other (specify)	- y		Month	Day Year	
P.O.	hat the ed by detac		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giv	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?	
ds, l	quires t en sign ould be	ted by	Chronic Obstructive Pulmonary Dise	ase		1 🗆	Yes 2 ဳ No 3 🗆	Probably 4 Unknown	
COL	aw rec as bee	Completed	Coronary Artery Disease			24a. Was	osy prior to	autopsy findings available o completion of cause of	
Re	The law cate has I					1 🗆 Yes	rmed? death?	? /es 2	
ital	sician certifi irector	m	25. Was case referred to medical examine 1 Xee 1 No Hospital: 1 Leastist 2 FR/Out	Tothe	ace of Death (Checker)				
of V	g Phys arthis eral di	e: To	27. Manner of Death 28a. Date of injury 28b. Tin	me of 28c. Injury	v at	-	dence 6 Other (Speniow injury occurred	ecify)	
ou o	ath. r: Afte	icat	2 Accident Investigation	jury work	? Yes 2 ☐ No				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office		28f. Location (S City or Tow	Street and Number or F	Rural Route Number,	
	spital		29a. Certifier 1 XCertifying Physician: To the best of my knowledge, de	leath occurred at the time	e, date and place, a	nd due to the ca	ause(s) and manner as	stated.	
	he Ho in 24 ł he Fur pletely	Medical	(Check 2 Medical Examiner: On the basis of examination and/or	investigation, in my opinio	on, death occurred at	the time, date a	nd place, and due to th	e cause(s) and manner stated.	
	To t		29d. Date signed (Mor	nth, Day, Year)					
		8	* Emf/ fall my		7947		OCTUBER	3, 2011	
	0		30. Name and address of person who completed cause of death (Item 23a) (Tyle Evelyn Jackson, M.D., 3416 Olandwo		uite 200	Olnev	Marvland	20832	
	Sta	e	31. Date filed (Month, Day, Year) 4 2011 32 egistrar's Signatury	hares	urcc 2009	, orney,	, laryzana	2002	
	Registra	ir	101 0 7 2011 December 10. 1	7					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0 2011 /Medical Stanley Daniel Andrykes 4a. Facility Name (If not institution, give street and 4c. County of Death **Examiner** Franklin altimore Square oseda Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months M 2□ F Director 9-28-1929 Maryland 218-22-1870 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits works if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examination until be notified at 1 ☐ Yes 2 ▼ No Director Md. Balto. Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 9608 Haven Farm Road Unit E 21128 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. No lifes 2 □ No lifes, Give 1951–1955 1 Never Married 2 Married "natural", or 1 ☐Yes 2 No Specify: White Maryland 21215-003 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Checker Marine Terminal 12thpermit. Pages 1 and 2 should be file Dep. riment of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Stanley_Andrykes Jennie Novakowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9608 Haven Farm Road Unit E Frances P. Andrykes Spouse Perry Hall, Md. 21128 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic crematory 10-3-2011 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek FuneralHome 21. Signature of Funeral Service License 9705 Belair Road Nottingham, Md.21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence offs that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy certificate 2 No 1 ☐ Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

12

State Registrar 31. Date filed (Mort

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Square Drive Baltimore Manylaro

amurer, MO, PhD

9000

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

anrier

n, Day, Year ---

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 9:38 PM 2011 Physician/ Morton Abrams Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Havard HOSPITAL Columbia County Genera Howard 9. Birthplace (State or Foreign 8. Date of Birth If Under If Under 24 Hrs. Country) NY Social Security Number 6. Sex 1 ፟፟ M 2 ☐ F 697737 1922 **Funeral** Days 89 Yrs. 075-16-1257 **Director** Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 🗆 Yes 2 🛚 No HOWARD COLUMBIA MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number by Funeral 21044 6336 CEDAR LANE, #319 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Black, White, etc. Armed Forces?
1 X Yes 2 ☐ No 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after oment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examir ury or other traumatic event, the Medical Examir 1 ☐ Yes 2 X No Specify: Maryland 21215-0036 Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) SYSTEMS ANALYST NSA 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) **MYERS** ဂ MARTHA **ABRAMS** JOSEPH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9052 BELLWART WAY, COLUMBIA, MD 21045 MICHAEL ABRAMS / SON Department of Healt Important: If item 2 any injury or other: Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/03/2011 CROWNSVILLE, MD MARYLAND VETERANS 4 Donation 5 Other (Specify) injury 22. Name and Address of Facility SOL LEVINSON & BROS., INC. permit. 21. Signature of Funeral Service Licence any in 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pneu monia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death signed by the aid be detached for 2 No 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown artery Division of Vital Records, Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? fibrillatio autopsy performed? Yes 2 1 Obstructive Discuse ulmonary 1 Yes 26. Place of Death (Check only one) To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Hospital or Attending Physician: examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at work? 5 Pending Natural 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 142892 29 hundh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia cedar Lane Francis

Year

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

			Please	Type or Pri							-		_	ble.	
			1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death							-	31455				
	Physicia Medi		1. Decedent's Name (First, Middle, La Louis Bancell		2. Date of						Date of Death Month F-FIRMBRI 29 2011 06:207				
	Examir		4a. Facility Name (if not institution, giv	LOF BAL	TIMOR	٤	4b. City	Town, or	Location			-	4c. County of	Death	1
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	ryland -f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Balti	more		Town or Loc	cation	-	_						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	ith the Ma 3a or 28a t be notif	ral Dire	10e. Street and Number 21300 Lentz R					0 Code 120					Citizen of Wh		untry?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If	Vas Dece Yes, spe	dent of His	n, Mexica	n, Puerto	cify Yes or No Rican, etc.)			Amer White	ican Indian,
Baltimore, Maryland 21215-0036	in 72 hours e. nan "natur Medical I	mplete	15. Decedent's I (Specify only highest g	L Education	5+)		ent's Usu and of wo NOT us	rk done di	ition uring mos	st of worki	ng	16b.	. Kind of Bus	iness I	ndustry
1d 21	iled with Il Hygien Other th	Be	10 17. Father's Name (First, Middle, Last)		''	Mail	Car	rier	18. Moth	ner's Name	e (First, Middle			sta	l Service
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e, M	1 and 2 sh of Health a fitem 27 is other trau		Carol Bancells (Date 20a. Method of Disposition				Lent	z Road		ton, I	Maryland	2112	20		·
timor	permit. Page 1 a Department of I Important: If ite any injury or ot		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	fy)	Bel Pe	metery crem Air Mem	orial	carde		Octob		Bel	Location - C	/ary	land
Bal	permi Depar Impor any ir		21. Signature of Funeral Service Lice	Ш							& Crema ton, Ma		3°27†19	s M	anktan
è	Physician/ , Medical Examiner		23a. Part 1. Enter the disease, or comshock, or wheart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each line S a	EP57	25	r the mod	le of dying	, such as	cardiac c	r respiratory a	arrest,			Approximate Interval Between Onset and Death
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68760	tificate b ng physi as the b	Medic	IF FEMALE:	d										+	
Вох	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	~ I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 🗌	Ectopic Other (s)		′				23d. Date Mont		very Day Year
ls, P.O.	requires that to been signed by should be deta	ed by PI	Part II. Other significant conditions of	ontributing to death b	ut not resul	ting in the ur	nderlying	cause give	en in Part	l.					the cause of death?
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al B	ding Physician: The la h. After this certificate hi funeral director, page		25. Was case referred to medical examiner?					26. Pla	ce of Dea	ath (Check	1 🗆 Yes	2 🔀	No 1	Yes	2 No
fVit	Physic this ce al dired	<u>٩</u>	1 ☐ Yes 2 No 27. Manner of Death			R/Outpatient			4 ⊔ N					(Speci	en HOSPICE
o uo	ending Physeath. or: After this he funeral di	Certificate:	1 Natural 5 Pending 2 Accident Investigatio			8b. Time of injury	M	8c. Injury work?			28d. Describe	how inju	ury occurred		
Division of Vital	tal or Att rs after di al Directo ed in by t	al Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	iry - At hom :. (Specify)	e, farm, stre	et, factor	, office			28f. Location City or To			or Rur	al Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu	Medical	(Check 2 L Medical Exam	sician: To the best of iner: On the basis of ex se Practioner: To the	kamination a	and/or investi-	gation, in	my opinior	n, death o	ccurred at	the time, date	and place	ce, and due to	the c	ause(s) and manner state
	To t To t		29b. Signature and title of certifier PVSTOR.	Prick M.	Э,			License		(Date signed (I		Day, Year)
5	x 1 V		30. Name and address of person who	completed cause of de M・D. Sまん	eath (Item 2	3a) (Type, Pr Н U S P.	int)	F BA	LTIM	ONK.	2401				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bruce R. Baird SEPTEMBER30,2011 12:49 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 213-50-4456 Months Days Hours Director 1**X**XM 2 \square F Yrs. 61 July 12, 1950 Maryland Usual Residence of Deced 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Maryland 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 617 Saint Dunstans Road 21212 of America 11. Marital Status Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. by 1 K Never Married 2 Married ☐ Yes 2XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: white If Yes, Give 3 Widowed 4 Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Wholesale Florist Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Samuel M. Baird Dorothy Lemke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara B. Shaw/sister 984 Forest Drive Arnold, Maryland 21012 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, remetery, crematory or other place)
Evans Funeral
Chapel—Bel Air October 3, ☐ Burial ②Cremation 3 ☐ Removal from State Other (Specify) 4 Donation 2011 Forest Hill, Maryland ral Service Licensi 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 21. Signatur 23a Part 1. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ ACUTE RESPIRATORY FAILURE Medical Due to (or as a consequence of): **Examiner** ANOXIC ENCEPHALOPATHY Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence or): as the burial-transit CORONARY ARTERY DISEASE that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical certificate be Box 68760 a ending JE FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Other (specify) for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I d be det 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, RECENT CARDIAC ARREST 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available Hospital or Attending Physician: The law this certificate has autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2X No Other: ၉ funeral dii 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Director: After 1 Natural 5 Pending iniurv death. Accident
Suicide Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the ! 29b. Signature and tith 29c. License number 29d. Date signed (Mpnth, Day, Year) D52096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID UTZSCHNEIDER, M.D. 7601 OSLER DRIVE TOWSON, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

OCT 0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 31457 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 27, Anthony Wilson Boduy 2011 1756 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 1**X**□ M 2 □ F Director T951 14. 579-66-0003 60 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🗀 No MD Laurel Anne Arundel 10g. Citizen of What Country? 0 10e, Street and Number 10f. Zip Code 23a Funeral 7903 Orion Circle #170F 20724 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.] ō δ 1 Never Married 2 Married 1X Yes If Yes, Give 21215-0036 Specify: African American/Haitian 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4X Divorced Completed Year or Dates. 1969-75 event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) USPS Supervisor marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Department of Health and Ment Important: If item 27 is marke any injury or other traumatic Wilson Anthony Boduy, Sr. Frances Delores Coates 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Sundew Rd. Savannah, GA 31411 Adrienne L. Williams/sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 09/29/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 Heverse MO1251Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MERATOCELLULAR CARCINOMA disease or condition WEEKS Medical resulting in death) Due to (or as a consequence of Examiner HEPATITIS C 4EARS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or). and -transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Day Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HUMAN IMMUNODEFICIENCY VIRUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🔲 No 1 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 🗷 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred To the Hospital or Autonomos within 24 hours after death. To the Funeral Director: Afte 1 XNatural 5 Pending 2 Accident
3 Sulcide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif 164395 SEPTEMBER 28,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA, MD 21044 6336 CEDAR LANE DOBERMAN, MD DANIEUE 32 Registrar's Signatu State Registrar

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9 Year .45A M HAROL D 2011 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month Day, Year) 1920 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**X** M 2 □ F **Director** Yrs New York 108-16-8496 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2X No MD Ellicott City Howard 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 5330 Dorsey Hall Drive #233 21042 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Amed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates 1942–46 Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: White Completed er than "natur, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tant: If item 27 is marked other tha lury or other traumatic event, the N 12 Director of Security General Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Beard Alice Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5060 Beatrice Way Columbia, MD 21044 Allison B. Kehoe/daughter Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 09/30/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Seft Going Home Cremation Service P.O. Box 784 MO1251 Heckrotte, P.A. Clarksville, MD 21029 Beverly L. 23a. Part 1. Enter the glease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HTHEROSCLEROTIC CARDIOVASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MULTILOBAR POVENMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 burst after death.
• Funeral Director: After this certificate has been signed by the attending physician and eled filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ☐ Live Birth ∠☐ 1 Geal Goath☐ Pregnant at time of death☐ Unknown Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Yes Certificate: To 2V No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Of De Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Within 2 only one) 29b. Signature and title of certifier MD 30 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sle eun mole

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 31460 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donnelly Blevins 3:22 P Sept. 26 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Joseph Hospital Baltimore Towson Social Security Number 6. Sex 8. Date of Birth (Month, Day, Ye July 31 1 If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 2011 Days Hours Yrs Director 215-34-0627 74 PA 1937 Usual Residence of Decedent 28a-f shov 10b. County 10a. State ed other than "natural", or items 23a or 28a-f showered the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 09/26/ 1 🗆 Yes 2 😾 No Baltimore Cockeysville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 International Circle 21030 **IISA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 XMarried 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify. white Completed 3 Divorced 4 Divorced VINS 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th n/a Maintenance MD Masonic Homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gaither Blevins Amanda Powers Department of Heath and Inportant: If item 27 is r. any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 International Circle, Cockeysville, MD 21030 Mary S. Blevins/wife Baltimore, Jounel 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/30711 N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Timonium, MD 21093 Gardens Dulaney Valley Memorial 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funera Michael 23a. Part 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause in each line. Immediate Cause (Final LOVI Ph_sician/ Lan diougson Arteriosclero disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on and physician at s the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Dav Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 2 No 1 ☐ Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examine. Yes Hospital Other: 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending neral Director: A 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practiceer: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 20816 ompleted cause of death (tem 23a) (Type, Print) Lutherville, Md Trimbl nth, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

'natural", or items 23a or 28a-f shov dical Examiner must be notified at

other traumatic event, the Medical

and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any lipiry or other traumatic event, once.

Director

Funeral

Completed by

Be <u>_</u>

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

led by the attending physician and detached for use as the burial-tran ate has been signed page 2 should be der

The law requires that the death certificate be executed

Attending Physician:

To the Hospital within 24 hours a To the Funeral D

Division or Vital Records, P.O. Box 68760,

Physician/Medical Examiner þ Completed ospital or Attending Physician: 1 hours after death. uneral Director: After this certificat ly filled in by the funeral director, ps Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of delivery Month Day Year										
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?									
Dlas	ETES Mellitus Type Z	1 Yes 2 No 3 Probably 4 Unknown									
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No									
25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
1 ☐ Yes 2 ☐ ₩o	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ■ Residence 6 □ Other (Specify)									
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury Work?	. Describe how injury occurred									
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exa	nysician: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)									

29c. License number

935102

Strict

29d. Date signed (Month, Day, Year) Septem BEV 30, 2011

Baltimore mary

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 0 4 2011

noul

29b. Signature and title of certifier

5901 Novih DON M.D. CHAYNA 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept 2011 Leona Blumenfeld :15am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Transitions Health Care Center Sykesvill<u>e</u> Carroll Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex **Funeral** (Month, Day, Year) Days Hours Min. 1 □ M 2 😿 F OH Director 289-16-0646 94 11 Usual Residence of Decedent 10d. Inside City Limits 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2X No MD Howard Cooksville 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number Funeral 978 Hoods Mill Road 21723 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes if Yes, Give 2 X No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 X Widowed 4 □ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Phillip Goska Elizabeth Klebowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ms. Gail Jones (Guardian) 125 Stoner Avenue, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🌠 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem Park 10/3/2011 Elkridge, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, ician/ Medical resulting in death) Due to (or as a consequence of) Examiner significant in the state of the Physician/Medical Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Hospital Other: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 \square Pending 2 Accident Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death 4c. County of Death Examiner Howard 8316 Ashwood Road Jessup If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Min (Month, Day, Year) 579-56-4951 1 - M 2XXF Director 03/27/1943 68 Wash., D.C. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d Inside City Limits 10c. City, Town or Location Director 1 Yes 2xx No MD Jessup Howard 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe Funeral 8316 Ashwood Road 20794 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? Black White etc. δ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White If Yes. Give 3XXWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (NAPA) Hygiene. Elementary/Secondary (0-12)
Grade 12 College (1-4 or 5+) Warehouse Clerk Automobile Parts other Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) and Mental ! is marked o ပ Ralph McKEaver, Sr. Edith Gilland other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Land 2 st Land 2 st Land 2 st I mportant; If item 27 is 1 any injury or other traum once. Hank Lawrence Belfield / son Chilhowie, Virginia 24319 permit. Page 1 and 2 532 Vance Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Washington Nat. Cem. 9/29/2011 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Avenue Laurel, Maryland 21. Signature of Funeral Service Licensee Gr M00770 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. Li Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Easer U dentiting Cause (Disease or injury Due to (or as a consequence of): attending physician and if for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Day Pregnant at time of death ate has been signed by the a page 2 should be detached Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably Unknown Division of Vital Records, Hospital or Attending Physician: The law requires Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 Yes 2 L 1 Yes 24 hours after death.

Funeral Director: After this certificately filled in by the funeral director, 25. Was case referred to dica To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27 Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: **U** Natural Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 3 | 464 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept. Physician/ Barclav 20 1°1 7:20 A Kathryn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 😾 F Months Days Hours Min. (Month Day, Year) 921 Pennsylvania 90 May Director 192-20-7574 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland must be notified at Director Garrett Park XX Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 10809 Clermont Ave. 20896 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. the Medical Examiner Armed Force 0 1 Never Married 2 Married Completed by 2**X** No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White "natural" 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Home other traumatic event. Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 2 (Unk) (Unk) Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26505 Roger S. Barclay / Son 675 Kenwood Pl., Morgantown, WV Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 10/05/2011 Beltsville, MD permit. 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner dequantially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): the attending physician Physician/Medical that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş page 2 should be The law requires 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No After this certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending hours after death. Ineral Director; A Investigation ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Sept. 30, 2011 D71962 On Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dan Marian Danila M.D., 8600 Old Georgetown Rd., 4th Floor, Bethesda, MD 20814

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 31465 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gillian Pame1a Boyce Sept. 29 2011 7:00am M Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🗓 F Hours (Month, Day, ept. 2 Country) Director 452-66-4192 Sept. England 1935Usual Residence of Decedent 28a-f shov with the Maryland 10a. State 10h County 10c, City, Town or Location 10d. Inside City Limits Director notified MD Baltimore 1 🗆 Yes 2🔻 No Owings Mills 10e, Street and Numbe ò 10f. Zip Code must be 10g. Citizen of What Country? Funeral 281 Owings Gate Ct. Apt. 102 21117 United States items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces ò ģ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2XX No Specify: "natural" Completed 3 X Widowed 4 □ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than College (1-4 or 5+) 2 years Elementary/Seconday (0-12) Maryland Public years Membership Television Ith and Mental Hygie 27 is marked other raumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Damon Lillian (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Andree Caropreso (daughter) other 1 1320 Old Westminster Pike Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town State \square Burial 2 XCremation 3 \square Removal from State ö Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc. 9-30-2011 Hampstead, MD vice Licentee 21. Signati of Funeral 22. Name and Address of Facility ELINE FUNERAL HOME J. Wayne Osterling 11824 Reisterstown Rd. Reisterstown, MD 21136 23a. Part 1. Enter the di shock, or heart fail ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Liner Underlying Cause (Disease or linjury Due to (or as a consequence of): -transit and that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 200 No Hospital 4 Nursing Home 5 Residence 6 Other (Specify) Other: မ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 10 Natural 5 Pending after death. 2 Accident
3 Suicide Investigation М 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 1pleted 1 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day)

SUITE 203

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

2835

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month **Physician** PM 1150 10 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Future Care Canton Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 04/04/1921 5. Social Security Number 6. Sex 7, Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🛣 F 216-14-1236 90 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified an once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🔀 No by Funeral Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5822 Shady Spring Road U.S.A. 21236 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 MaNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify. Specify: 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gus Ehatt Ruth 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Bittle, Daughter-in-law 2727 Crescent Lane Gastonia, NC 28052 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 10/04/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Cleandua 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 101 vance disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 WNo 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Jal 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🛱 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

adias 1300 S. Ellw.
32. Egyottar's Signature
2011 Anna S. Jane

ted cause of death (Item 23a) (Type, Print)

2

Avenue, Baltimore MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Austin Sylvester Bortner Jr. 30 2011 Sept 4:38P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing Home Carroll Taneytown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** . Age (In vrs. last birthday 8. Date of Birth 1 **X**M 2 □ F Month Day, Year) 28 218-32-3912 Months 82 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 and any injury or other traumatic access. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Carroll MD Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2726 Littlestown Pike 21158 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. 3 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) silk screen painter technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Austin S. Bortner Sr. Elizabeth S. Tressler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 19a. Informant's Name/Relationship (Type, Print) Doris H. Bortner 2726 Littlestown Pike, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐**X**Burial 2 ☐ Cremation 3 ☐ Removal from State Sandymount Cem. 10-5-2011 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Fletcher Funeral Home homas I 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final net and Death Pnysician/ pour disease or condition resulting in death) up Medical or as a consequence of: Due to **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transif that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) __ To the Hospital or Attending Physician: The law requires that the death in the past 12 months? Month Pregnant at time of death 1 Yes 2 L 9 Unknown the g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sh 24a. Was an autopsy performed? 1 Yes 2 No : After this certifical funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 🗷 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu death. 1 Yes ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati and title of certifier 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 31468 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 30 201 1:55A M Jack С. Brownson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Greater Baltimore Medical Cente Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 X M 2 D F Months Days Hours Min 10/28/1925 212-20-3875 85 Yrs. Director Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 V No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 8810 Walther Blvd. Apt. 1118 21234 United States Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian rmed Forces?

X Yes 2 No 1943Yes, Give 1946 Black, White, etc 1 Never Married 2 Married ģ 1946 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Advertising Sales vrs Be rdun SON, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Wallace Brownson Laurabelle Hannan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, MD 21234 Mrs. Mary Anne Brownson wife 8810 Walther Blvd. Apt. 1118 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) Entombment Glen Haven Mem Park 10/04/2011 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Singleton Funeral & Cremation M01121 Services, PA; 2nd Ave SW, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the a Id be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 Probably 4 Unknown Completed peen 240. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autonsy perform Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury Natural 5 Pending 2 🗌 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 02 20 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Mandrin Hospice House Harwood 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Numbe **Funeral** 7. Age (In vrs. last birthday) (Month, Day, Year) Oct. 18, 1939 1 M 2 F Days Hours Min. Maryland Director 219-26-4729 71 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland be notified at Director 1 Yes 2 No Millersville Marvland Anne Arundel 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 23a must 21108 544 Valleywood Road United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker/Regulation Coordinator St. of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Carl Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brandie Allen 106 Emerson AVe, Glen Burniem MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗶 Bur(al 2 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) <u>Glen Haven Memorial</u> 10/08/2011 Glen Burnie, MD 21061 21. Signature of ce Licens e Funeral S 22. Name and Address of Facility Kirkley Ruddick Funeral Home 21 Crain Highway, S.E., Glen 21061 MD Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence on: Due to (or as a consequence of): resulting in death) Last the burialattending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 🗌 Yes 2 🗌 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 L No MANDRIN 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical within 24 hou

To the Funer

completed file 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check crtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 100 10 Q. Name and address of person who of death (Item 23a) (Type, Print) ENSE HWY, ANNAPOL ENEVIE Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 31470 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 0755 AM BUTGAN 412thur 1105 extember Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAltimore University of MARWAND Medical Center 9, Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 5. Social Security Numbe 7. Age (In vrs. last birthday) 6. Set **Funeral** Country) Maryland Months Days Hours Min Mar. 28 ^{'ear}1946 1 🗆 M 2 🔀 F 65 Director 262-90-1382 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a, State 10b County 10c. City, Town or Location Director 1 Yes 2 No Towson Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with Apartment 202 21204 United States 31 Ruxview Court, or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15, Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry المالية. عا Hygiene. عاد than "r (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Graphic Design Customer Service 2 should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy Jackson Richard Burgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i MD 21093 Timonium, 1127 Greenspring Valley Rd., Gail Gann / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/01/2011 Baltimore, Maryland Metro Crematory Inc. 22. Name and Address of Facility Cremation Society of Maryland Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ itilos disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ATTOCKUTS 119 Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (a consequence of) transit and that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? ò Year Month Day Pregnant at time of death signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed plnous пеес Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician; The law within 24 hours after death.

To the Funeral Director, After this certificate has autops perform death? Yes 2 No 1 Yes 2 No 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Hospita Other: 2 X No 1 Tes မြ 1 Natient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural iniury 5 Pending Accident Investigation the 1 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 316246598 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S Greene

DHMH 17 Rev 7/2009

State Registrar Shwllake

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Henry Lee Cote	1- For State Registrar	State	of Marylan			Health and Death	l Mental H		20 l	1 3 1 4 7 1		
Physician/ Medical Examiner	1. Decedent's Name Hen	ıry	Lee	Cot		2. Date of Dear Month October 1	Day Year , 2011	3. Time of Death 1211 hrs				
	4a. Facility Name (if 4617 Niney Co. Social Security Nu			ar) d Age (In yrs, last bi		b. City, Town, or L Reisterstown	0 1	eysville	4c. County of De Baltimore C	ounty		
Funeral Director	214-26-128 Usual Residence of I	80 1 <u>X</u>		81		18, 1930 Foreign Country) MD						
nd how any Es.		0b. County	ltimore	10c. City, Tow		on Reisterst	OMB			10d. Inside Cify Limits 1 Yes 2 No		
the Maryland a or 28a-f show any tiffed at once, Director	10e. Street and Num					10f. Zip Code	21136	1	0g. Citizen of What C	ountry?		
er death with 1, or items 23, r must be not	11. Marital Status 1 Never Married	d 2 Married	12. Was Decede Armed Force		If Ye	s Decedent of Hisp es, specify Cuban,	Mexican, Puerto		White, etc			
2 hours after "natural", "Examiner eted by	X Widowed 15. Decedent's Edu Elementary/Secon	ıcation (Specify or	If Yes, Giva Yaar or Dates: hly highest grade of College (1-4 of	during m		Yes 2 X No "s Usual Occupation out of working life. I	on (Give kind of v		Specify: 16b. Kind of Busines	White ss/Industry		
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "matu e event, the Medical Exan FO BE Completed	17. Father's Name (F	First, Middle, Last)	5 +		F	Professor		e (First, Middle, M	Educa Maiden Surname)	tion		
D 2121; should be fil and Mental I; is marked satic event, i	Edwa	ne/Relationship (T		1	_	•			Pinckey	ate, Zip Code)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Glenn 0. 20a. Method of Dispo	osition Cremation 3		20b. Place State crema	of Disposi atory or oth	Addison tion (Name of cemer place) Mem. Gar	etery,	Date	20c. Location - City	or Town, State		
Baltin permit. P Departme Importar injury or	21. Signature of Fundamental Conference of F	Other Specify:		nKin	22. N	ame and Address o	of Facility 11	824 Reis	sterstown erstown, M	Road		
Physician /Medical 5xaminer	Immediate Cause (Fi	one cause on ea								Approximate Interval Between Onset and Death		
	Sequentially list conditioning to imm	ditions, b	Due to (or as a co									
0, be executed sician and ourial - transit edical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
50, te be executed sysician and burial - transit	UNPENDED	d	AMENDED	come of pregnancy	,				23d, Date of deliv	erv		
Division of Vital Records, P.O. Box 6876i To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tedical Certification: To Be Completed by Physician/Me	If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown									Day Year		
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Division To the Hospital or Attentwithin 24 hours after death within 24 hours after death To the Funeral Director. completely filled in by the	Suicide 4 Homicide 29a. Certifier	6 Could not be determined	(Specify)	lajor Road / H	lighway			or Town, S NB I83 and Sh	itate) nawan Road , Cock	eyville, MD		
To the Howithin 24 h To the Fun completely Medical	Check only 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier											
(3)	30. Name and address	ss of person who c	completed cause o	f death (Item 23a)		O.C.M	1.E.		October 2, 201	1		
State	Ana Rubio M 31. Date filed (Month,			rar's Signature	W. Baltii	more Street, B	Baltimore, Mi	D 21223				
Registrar DHMH 17 Rev 1/2001 OCME 2006	QCT.	0 4 2011	Leven	J. Joi	RIGINAL			-	OGME			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 | 472 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day Year SEPTEMBER 29,2011 12:32PM SONG HAE CHUNG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Jan 3, 1934 Social Security Number 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** Country) South Korea 1 X M 2 □ F Months Director 220-84-6935 Jan Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at Director 1 X Yes 2 No MD Frederick Thurmont 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21788 USA 7340 Blue Mountain Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give "natural", or ģ 1 Never Married 2 X Married within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Service Business Owner Be Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Hong-Soon Yoon Haeng-In Chung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3012 Larkin Road Boothwyn, PA 19061 Unchin Chung/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Final Journey Crematory 10/05/11 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD Signature of Funeral Service License 22. Name and Address of Facility
Going home Cremation Service P.O. Box 784 Heckrotte, P.A. Clarksville, MDBeverly L. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ANGELE disease or condition resulting in death) Medical Due to (or as a consequence of) ocardia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) and I-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): y physician a Physician/Medical attending IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of the W use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page certificate 1 ☐ Yes 2 ☐ No. Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No ဂ္ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MICHAEL TOLINO MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) radarick 21702 5 a neu 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

of Vital

Division

Box 68760 P.0. Records, Division of Vital

DHMH 17 Rev 7/2009

State Registrar

29b. Signature and title of certific

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License numbe

1650 Orleans Street, Baltimore, Maryland 21231

D66346

29d. Date signed (Month, Day, Year)

September 29, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31474 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 28^{ay} Diann Elizabeth Clark 2011 6:35 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Havre de Grace Harford Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Hours 12/24/1949 61 Kansas **Director** 215-56-6059 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** 28a-f Aberdeen 1 X Yes 2 No MD Harford 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21001 USA 61 Baker St. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces Black, White, etc 0 1 X Never Married 2 Married þ 1 ☐ Yes 2 XNo If Yes, Give Year or Dates. Maryland 21215-0036 White 1 Yes 2 XNo Specify. "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 ath and Mental Hygiene.
27 is marked other than "1" traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 12 Purchaser Education 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruby Wheelock William Clark permit. Page 1 and 2 st Department of Health an Important: If item 27 is m any Injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Locust St, Perryville, MD 21903 Patricia Juchniewicz/sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Gdns. 10/4/2011 Aberdeen 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Tarring-cargo Funeral Home, 333 S. Parke St, Aberdeen, I P.A. MD 21001 ranie Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence oil sician and burial-transit Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death asn 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2XXNo for 1 Year Month Day Pregnant at time of death Unknown detached 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: ᅆ 4 Nursing Home 5 Residence he Funeral Director: After this colleted filled in by the funeral di 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit on who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

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Acevedo-Villa

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104 Plumtree RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Physician/ 30 20 11 MOLAIANNI 8:45 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death cH Balth more BAITIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Country) Director 217-01-9262 102 .19d9 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Balto. Nottingham 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8326 Cypress Mill Road 21236 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Seamstress Tailor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev Rosario Fulco angelina Bianca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Ashford Road Parkville, Md. 21234 Donald J. Palughi Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Most Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 10-4-2011 Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Pail 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Demen disease or condition resulting in death) LNC Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exam Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗔 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the leted filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗌 No 2 Accident 1 🗌 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 only one) 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 1 1 3 1 4 7	6
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death 3. Time of Death	th
	Physicia Medic		COLLEEN DAWSON Worth Pay Zoil 10:10A	М
	Examin	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 60LDEN LIVING CENTER 4c. County of Death FREDERICK	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) Months Days Hours Min. (Month, Day, Year) Months Days Hours Min.	эign
	land show dat	r	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	nits
	Maryla 18a-fs tified	Director	MO. FREDERICK FREDERICK 18 YES 2 [] No
	72 hours after death with the Maryland ""natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Funeral Di	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/7 01 USA	
	r death or items uiner mu		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Right) Hispanic Origin? (Specify Yes or	
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21215-0036	within 72 he giene. ier than "na ; the Medic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)	
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Maryland	should to and Me I is mark raumati		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1135 YOUNG PLACE FREDERICK MD 20701	
oî.	e 1 and 2 of Health If item 2 or other 1		20a. Method of Disposition 20b. Place of Disposition (Name of completely crematory of other place) 20c. Location - City or Town, State	
tim	t. Pag tmer tant tant		4 Donation 5 Other (Specify) HOPEHIU Con. Oct. 6, 2011 PREDERICH, M.D 21. Signature of Funeral Service Licensee 222. Name and Address of Facility Con. 1. Rollings Gar. Home	-
Ba	permir Depar Impor any in	ļ. Ņ	21. Signature of Funeral Service Licenses 22. Name and Address of Facility CARTL. ROLLING FOR HOME WAST SOUTH ST FREDERICK MD 2,701	_
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Divisi	al or Atters all all all all all all all all all al	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
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	To the within 3		29b. Signature and title of certifier ### MD. 29c. License number 29d. Date signed (Month, Day, Year) 10/4/11	
-			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Hague 700 Montalaire Ave Frederick MD 21701	
L	Stat Registra		31. Date filed (Month, Day, Year) OCT 0 4 2011 32. Registrar's Signature facular	

P.O. Box 68760 Division of Vital Records, Puospital or Attending Physician: The law 24 hours after death.
Funeral Director. After this certificate has law.

Physician/

Medical

10a. State

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Examiner

Funeral

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Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event,

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Baltimore, Maryland 21215-0036

Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by icate has been si 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ၀ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) RIN1944 ichealle 10/3/2011 Cour. NSW eted cause of death (Item 23a) (Type, Print) 30. Name a address of person wh SSOO utilther Blud, Parkville MP21234

32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 4

completed filled in by the funeral director,

To the within 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month 09 Physician/ 23:22M 201 Medical Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death give street and number, **Examiner** Medica lary/44 9. Birthplace (State or Foreign If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖵 F Months Days Hours Min NoV. Day O'ea ar) 1935 °Maryland 75 219-32-7288 Yrs. Director Usual Residence of Deceden 28a-f shov 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director Examiner must be notified 1 ☐ Yes 2 💢 No MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? ö 10e, Street and Numbe items 23a Funeral USA 21061 316 Williams Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc ò 1 ☐ Never Married 2 🕅 Married ۾ Maryland 21215-0036 72 hours after ☐ Yes 2 No Yes Give X If Yes, Give Year or Dates 1 ☐ Yes 2 ₩ No Specify: Specify.White item 27 is marked other than "natural", other traumatic event, the Medical Exal 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or con-ဂ Ina Puttman Albert Cameron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Williams Road Glen Burnie Maryland 21061 Richard Dash-Husband Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 29.201 Glen Burnie Maryland Crematory Sept. 22. Name and Address of Facility Ambrose Funeral Home Inc. 0 Sulphur Spring Road Arbutus Maryland 1328 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Directo (or as a do recquerde of, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events -transit Exami and Due to (or as a consequence of): resulting in death) Last attending physician a Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the detached 9 Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed Yes 2 has within 24 hours after death.

To the Funeral Director: After this certificate or Attending Physician: 25. Was case referred to medica director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 횬 1 Tyes 2 **N**O 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 2 🗌 No 1 Tes Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) e and title of certifia 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signatu

State Registrar

DHMH 17 Rev 7/2009

Date filed (Month,

Day

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Constrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Specifical Control of the Control of		Amend #26	Please , per MD	e Type or Pr G920, 10/2 State of N	int in I	Black Ir TRT Depa	ndelible In	k. Ensure Health and	All Copies d Mental Hy	s Are I giene	Legible.			
	•	State Registrar			,		tificate of l			Reg. No	011	31479		
Physicia	n/	1. Decedent's Name	e (First, Middle, La	ast)	•	-		2. Date of De	Death 3. Time of Death					
Medic	al		Philip 1											
Examin	er	4a. Facility Name (if not institution, give street and number) 4430 Bucks School House R					4b. City, Town, o	ale		County of Death				
Funeral Director		5. Social Security Nu 213-46-	-1972	Sex. 1 X M 2 □ F	ge (In yrs. la 68	3 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		08, 1	9. Birt 942 Ma	hplace (State or Foreign untry) aryland		
ryland -f show ied at	Director	Usual Residence of 10a. State	10b. County		1	, Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 📈 No		
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/lar d be f Menta arked	ပု	Philip	Ernest 1	Deigert										
Maryland 21215-0036 d 2 should be filed within 72 hours after aith and Mental Hygiener all matural", o artraumatic event, the Medical Exam		19a. Informant's Na Elva I	me/Relationship Martens /	, , ,						er, City or Town, State, Zip Code) d. Rosedale, MD 21237				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health and Health and Hygiene. Department of Hygiene. Department of Hygiene		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)				emetery, cren	sition (Name of natory or other place ake Crem	Town, State le, Maryland						
Balt permit. Depart Import any inji		21. Signature of Fur	neral Service Lice	Remo	Mois	35 22	Name and Address Cremation 8717 Green	ess of Facility on and Fu een Pastu	neral Alt res Drive	ernat	ives on Mary	land 21286		
Ph_sician/		shock, or hear Immediate Cause (disease or conditio	rt failure. List only Final	mplications that cause one cause on each lin	ed the death	scles	/ _/	/	or respiratory ar			Approximate Interval Between Onset and Deat		
Medical Examiner	ī	resulting in death)	nditions	e to (or as	s a consequ	ience of):								
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Euneral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the buse.	Physician/Medica	23b. Was decedent in the past 12 r	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)											
S, P.O.	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco										o the cause of death?		
Division of Vital Records, ral or attending Physician: The law requires is after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed by								24a. Was auto perf		prior to death?	itopsy findings available completion of cause of		
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on of nding P ath. :: After t	icate:	27. Manner of Death 1 Natural 2 Accident	n 5 ☐ Pending Investigati	28a. Date of in (Month, D	jury lay, Year)	28b. Time of injury	wor		28d. Describe	how injury	occurred			
Divisic Divisital or Atte tal or Atte s after de al Directo ed in by th	l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of Ir	njury - At ho etc. (Specify		eet, factory, office			Street and wn, State)	Number or Ru	ıral Route Number,		
the Hospit iin 24 hour the Funera	Medical	(Check 2 only one) 3	☐ Medical Exa	nysician: To the best on miner: On the basis of urse Practioner: To the	examination	n and/or inves	tigation, in my opin death occurred at the	ion, death occurr he time, date and	ed at the time, date	and place, a ne cause(s)	and due to the and manner as	cause(s) and manner stated. s stated.		
To 1 Norith		29b. Signature and	-)Men	HIN				4337		09/	30/3	2011		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 1445 2011 Angela Epp1e Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT MEMORIAL HOSPITAL @ EASTON CASTON If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex Age (In vrs. last birthday) Social Security Number **Funeral** Months Days Hours Min 1 - M 2X X F 16777733 79 PA 288-26-8354 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director must be notified 1 Yes XX No MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Number 23a Funeral USA 21061 200 Longwood Ave items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 5 1 Never Married 2 Married ò 1 ☐ Yes XX No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed the Medical Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Artist permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Elizabeth Ruby George Mavros 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21061 200 Longwood Ave Mr. Richard Epple, Sr. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 XX remation 3 Removal from State 10/4/2011 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Jureral Service Lice Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Part 1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed Exam that initiated events resulting in death) Last burialphysician s the burial Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death 2 700 the 9 Unknown P.O. I ò 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, pagr Yes 25. Was case referred to medica 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name and address of person who complet

DHMH 17 Rev 7/2009

State Registrar

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32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 Month 9 Physician/ 905 PM LATHERINE EATON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3511 GMYNN BALTIMORE KESTON DAK If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 219-31-7633 Months Days Hours Min. (Month, Day, Year) Director 1 🗆 M 2 🔀 F Yrs. 07/07/1910 West Indies 101 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location rector 1 Yes 2 No MD Baltimore Co. Gwynn Oak ā 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ō Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be Funeral 21207 Antiqua 3511 Keston Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc Armed Force þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2√ No Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 8th Grade College (1-4 or 5+) Self Employed Seamstress ath and Mental Hygien 27 is marked other ther er traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosilind Gomez permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. James Jarvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3511 Keston Rd., Gwynn Oak, MD 21207 Alphonse Warner(son) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State on-site Crematory 10/05/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licers Josephors of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL NFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-trar and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Pregnant at time of death Month Dav 5 Other (specify) detached the s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 HypERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate has page 2 1 Yes 2 X No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation within 24 hours after deat

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, DTay D0064307 9 /28 2011 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VITBERL MD St. Paul Place BALTIMORE, 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 11-07329

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Peter Alan Ebstein	State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No. 2011 31482
Physician/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1651 brs
Modical Examiner	Peter Alan Ebstein September 29, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	6225 Sandy Point Road Prince Frederick Calvert
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign New Worths Days Hours Min.
Director	585-59-499/ 1XM 2 F 36 Yrs. 11/13/19/4 Country Jersey
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
k	Maryland Calvert Prince Frederick 1 Yes 2 X No
the Maryland a or 28a-f sh tiffed at one Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
h the N 34 or 3	2384 Sixes Road 20678 United States
r death with or items 23 cmust be no Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
ter de: ", or i	1 Yes 2 X No 1 Yes 2 X No specify: Specify: White
ours after attraction and by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
5-0036 ed within 72 hour bygiene. other than "natu hts Medical Exat Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 Laborer Construction
d withing distribution of the complex	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical To Be Comple	Lawrence Ebstein Linda Braby
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chi Ebstein / Wife 20710 NW Longbow Ln., Beaverton, OR 97006
and 2 sho lealth and tem 27 is traumati	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: Metro Crematory Inc. 10/03/2011 Baltimore, Maryland
altin mit. P partme portan ury or	21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland
	299 Frederick Rd., Baltimore, Maryland 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Returns Open and
Physician /Medical	failure. List only one cause on each line.
£xaminer	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
	Sequentially list conditions, bb.
iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
ted Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
te be executed ysician and burial - transit	d. UNPENDED AMENDED
60, ate be hysicie buria	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
6876 certificate nding phy se as the b	23b, Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (Specify)
). Box 6876(the death certificate by the attending physical so the behavior of the sorter Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown
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Records, The law requires ficate has been sig. page 2 should be	autopsy prior to completion of cause of performed? death?
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fital sician sician is certificated	examiner? Hospital: 4 Innetion 2 FR/Outnetient 3 DOA Other Nursing Home 5 Residence 6 Other Scene
of Ving Physical Circle Children	27. Manner of Death 1 Natural 5 Rending Pound: 28b. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Rending FOUND: 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No Subject hung self and cut self
ion trendi death. ctor: /	1 Natural 5 Pending Investigation 2 Accident Pending Investigation Pending Investigation 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division of Vital Records, P.O. Box 6876/ suptal or Attending Physician: The law requires that the death certificate hours after death. Internal Director. After this certificate has been signed by the attending phy y filled in by the funeral director, page 2 should be detached for use as the b Certification: To Be Completed by Physician/MA	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 625 Sandy Point Road , Prince Frederick , MD
2 2 2 2 3 3 C	
To the Hos within 24 h To the Fur completely	(check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F S F S	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Co.C.M.E. September 30, 2011
	(/ collectible yell
)	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State	SWAW I SO SWAW I SO SWAW I SWA
Registra	OCT 0 4 2011 Denum B. Have

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** IRGINIA UCTOBER 2011 +ULTON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BAITIMORE Atonsville 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Security Number 6. Sex **Funeral** Days 1 M 201F Hours - 3160 FED 2, 1921 VIRGINIA Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 10d. Inside City Limits sa or 28a-f show t be notified at 10b. County 10c. City, Town or Location 1 Yes 2 No Director timore MARYLAND 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ?7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Ho Baltimore, Maryland 21215-0036 Specify: African AMERICAN þ 3 Widowed 4 □ Divorced Completed 16b. Kin of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Domestic Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AMES COUISE King วนกก DUNK ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau DALTIMORE, 20b. Place of Disposition (Name & cemetery, crematory or other place) Wanita drushter Date 20c. Location 20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ Removal from State Oct. 12 2611 Woodlawn MARYLAND Memorial 4 ☐ Donation 5 ☐ Other (Specify) SING 22. Name and Address of Facility
WARDER M. WALLACE FUNERAL SER
3405 W. Franklin Steet-BAltimore FUNERAL SCRUICE 21. Somewire of Funeral Service Lice MARYland 2/228 Approximate Interval Between Onset and Death disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROSCLE ROTIC CEREBROVASCUL **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence on) Examine and Box 68760 Due to (or as a consequence of): physician a the burial-1 Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an YPERTENSION autopsy performe 2∐ No BREAST ANCER 1∐ Yes 2 No 1 ☐ Yes this certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation or Attending Injury 1 □ Yes 2 □ No death. after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO AKHANIS 2835 HILIUSS TASNEEM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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		-	For State Registrar	State o	of Mar	yland /		rtment tificate			nd M	ental Hy	giene _{Reg. No} 2	0.1	1	31	l. Q l.	
			Decedent's Name (First, Middle	, Last)				.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				2. Date of Dea	ath	<u>U 1</u>	-	3. Time	7 0 7	٦
	Physicia Medic		Lillian Elis	sabeth Fai	rina								otember 30, 201			8:37		
	Examin		4a. Facility Name (if not institution Gilchrist Hos		,			4b. City, To		ocation of	Death		4c. County of Death Howard					
	Funeral		5. Social Security Number	irthday)	If Under 1	Year Days	If Under 2	4 Hrs. Min.	8. Date of Birl	Date of Birth 9. Bir			n/l	or Foreign	_			
H	Director		088-28-8512	74	Yrs.	Months	Days	Hours	IVIIII.	Feb. 2,	1937		Count	NY NY	<i>I</i>			
	ind show at	ř	Usual Residence of Decedent 10a. State 10b. County		10	Oc. City, To	wn or Loc	ation							10)d. Inside	City Limits	_
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	vith the l 23a or 2 st be no		10e. Street and Number 333 Old Line	Ave.				10f. Zip C		10g. Citizen of What Country? USA								
'	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar	12. Was Dece Armed For	rces?	in U.S.		/as Deceder Yes, specify				cify Yes or No- Rican, etc.)	14	14. Race - American Indian, Black, White, etc.			-	
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Maryland 21215-0036	12 shou lith and 27 is m r traum	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Laura Claudy/ Daughter 2035 Kays Mill Road, Fink																
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<u><u>ä</u></u>	Page tment tant: It jury or		1 🛣 Burial 2 □ Cremation 4 □ Donation 5 □ Other (State		etera	ans Ce	mete	ery		er 7,		nsvil	_			_
Ball	permit Depart Impor any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Service Licensee M01053 313 Talbott Ave., Laurel, M												ome,	P.A	•	
			23a. Part 1. Enter the disease, or heart failure. List of	complications that only one cause on ea	caused the	e death. Do	o not ente	r the mode o	of dying,	such as ca	ardiac o	r respiratory ar	rest,			Approxim Interval B	etween	
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687	ertifica ding pl		IF FEMALE:	23c If yes our	tcome of r	regnancy												
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Division of Vital Records,	ne law rec e has bec age 2 sho	omple	IDIOPATHIC TUROMBOCYTOPENIC PURPURA 24a. Was an autopsy prior to death?									r to coi	osy finding mpletion of 2 No		Ī			
<u>a</u>	ian: Ti artificat stor, pa	Be C	25. Was case referred to medical examiner?						26. Plac	ce of Death	(Check	1 \(\text{Yes} \)	2 X NO		res	2/23/140		
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	To the within To the compl	Σ	29b. Signature and title of certifie	Nurse Practioner.	TO THE DES	st Of Thy Kild	owieage, a	29c. L	icense i	number	ariu piac	e, and due to tr	29d. Date	signed (M	onth, l	Day, Year)		-
			100	2/1)).	~				16	439	5		007	OBE	R	1,20	11	
	10		(Check 2 Medical I only one) 3 Certifying 29b. Signature and title of certific 30. Name and address of person DANIEUE DC 31. Date filed (Month, Day, Year)	who completed cause	se of deat	h (Item 23a	a) (Type, P	rint)	EDA	AR L	AN	E CC	um	BIA,	M	D 2.	1044	
	Star Registra	te ar	31. Date filed (Month, Day, Year)	4 2011 32.4	egistrar's	Signature	. As	ale										_
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND ITEM#12perFH,G920,10/4/2011,WS State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician/ <u>Grover</u> Fisher 9 2011 6:06 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death N/A 1708 Bond Street Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Days Hours Min Months Yrs **Director** 81 251-38-9953 S.C /1930 Usual Residence of Decedent 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Baltimore MD N/A ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21213 1708 N. Bond Street USA items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify.Black "natural", Completed 3 Divorced 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than ulth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Laborer 10th M/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil thment of Health and Mental rtant: If item 27 is marked or jury or other traumatic ew 2 Jeanette Johnson Alexander Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natalie Fisher-Daughter Bond St. Baltimore, MD 21213 1708 N. Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If is any injury or o 1.X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 10/4/2011Owings Mills, MD permit. 22. Name and Address of Facility March F/H 1101 E. North Signature of Europeral Service Licenses 21202 Ave. Baltimore, MD an. 23a. Part 1. Eyter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ rung mony disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ō Month Day Year Pregnant at time of death cate has been signed by the a page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/2 No certificate 1 Yes 2 No 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death Natural 28b. Time of 28c. Injury at 24 hours after death.

Funeral Director: After 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical (Rertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29c. License number 29d, Date signed (Month, Day, Year, 29 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 MENUIT mitt 203 31. Date filed (Month, Day, 32 Registrar's Signat ark Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 28 2011 4.00 A M Alice Louise Ford Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) If Under 8 Date of Birth Funeral Year 1918 Country) Maryland 1 M 2 F Min. Apr. 20 Director 215-01-2149 93 Usual Residence of Decedent 28a-f shov 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Lancaster Lancaster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2504 Raleigh Drive 17601 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc id Mental Hygiene. marked other than "natural", or Ş. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Worker Investments Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 2 George Ferdinand Hartzell Annie W. Lohmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2504 Raleigh Drive, Lancaster, Pennsylvania 17601 Mary E. Rose / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 10/1/2011 Parkwood Cemeterv Baltimore, Maryland onation 5 🚺 Other (Specify) 21. Sig 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death 1552 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or impury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Physician: The law certificate has autopsy performed? Yes 2 No pade 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) funeral director. examiner?
1 Yes 2 No Hospital: Other: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 DNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) o the Hospital or Attending Pluthin 24 hours after death.
o the Funeral Director: After the ompleted filled in by the funeral Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 3 2 2 5 5 Down 5 September 28 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

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		•	For State Registrar	State of Ma	ıryland		artment of ⊦ tificate of £		d Mental Hy	giene Reg. No. 0		31487		
	Dhysisia	~/	1. Decedent's Name (First, Middle, L	ast)					2. Date of De		2011	3. Time of Death		
	Physicia Medio		Lee Roy Grubb						Octobe		3:25 A M			
	Examin	er	4a. Facility Name (if not institution, gi				4b. City, Town, or		eath	4c. Coun	ty of Death			
	Funeral		Genesis Healthc 5. Social Security Number 6.	Sex 7. Age	(In yrs. las	st birthday)	Baltimo If Under 1 Year	If Under 24 H		th	g. Birth	place (State or Foreign		
	Director		220-36-1628	1 🗷 M 2 □ F	7	l Yrs.	Months Days	Hours M	in. (Month, Da 02/13	″19″40	West	Virginia		
	nd how at	r	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits		
	larylar 3a-f s iffied	Director	MD		Ba T	ltimor	e				1 🛛 Yes 2 🗌 No			
	the N a or 28		10e. Street and Number		Du.	re rinor	10f. Zip Code	-		10g. Citizen of What Country?				
	h with	Funeral	124 W. Franklin				21225			U.S.A.				
	r deat or iten iiner r		11. Marital Status1 X Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 X Yes 2		13. V	Vas Decedent of Hi FYes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ace - Ameri ack, White,			
21215-0036	s afte ral", c Exan	ed by	3 Wildowed 4 Divorced	If Yes, Give Year or Dates.	40	1	☐ Yes 2 🔀 No	Specify:		Specify: American Ind:				
2-0	2 hour "natu	plet	15. Decedent's (Specify only highest			(Give I	lent's Usual Occup	ation during most of v	working	16b. Kind of	Business In	ndustry		
12	ithin 7 ene. • than he Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	+)		o NOT use retired) kkeeper			Medical				
d 2	lled w I Hygi other	Be	17. Father's Name (First, Middle, Las	t)			Kite e pe z	18. Mother's I	Name (First, Middle		ame)			
ylar	d be f Menta arked atic e	욘	James Harlow	Grubb			Reedi	s Jose	ohine	Mile	S			
Maryland	2 should be filed within 72 th and Mental Hygiene. ?7 is marked other than "! traumatic event, the Med		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 7811 Keenan Road, Glen Burnie, MD 210											
100	and 2 Healtl tem 2		Mary Postick / 20a. Method of Disposition	Sister	20b. Pla		. Keenan .	Road, G	Date Dutil	20c. Location		Fown, State		
mor	age 1 ent of nt: If ii		1 ☐ Burial 2 ☐ Cremation 3 4 🔀 Donation 5 ☐ Other (Spe			-	natory or other place fts Registr		/03/2011	Hanove	er, Ma	aryland		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of uneral Service Lix		1230	22	. Name and Addres	ss of Facility	Anatomy	Gifts	Regis	try		
_	20 E # 9	N 19	1000								over,	MD 21076		
	S		23a. Part 1. Enter the disease, or or shock, or heart failure. List only Immediate Cause (Final	omplications that caused one cause on each line	the death	. Do not ente	er the mode of dyin			rrest,		Approximate Interval Between Onset and Death		
	Pnysician/ Medical		disease or condition resulting in death)	a. Due to (or as a	conseque	ence of):	cou	on co	an Cer		-+	6 months		
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	7 ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	ence of):								
	ecuted and -trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):					\rightarrow			
0	be ex sician burial	dical	rooming in adding and	- d	·	,								
3760	ficate g phy: as the	Nedi		_ u						-1-				
Box 687	tendin r use	ian/	IF FEMALE; 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Fetal	death 3	Ectopic pregnanc	у		23d. Date of delivery				
Bo	ss that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Physician/Me	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5 L	Other (specify) _			Month Day Year				
P.O.	that th		Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?		
ds,	v requires been sign should be	ed b							_ 1 □	Yes 2 No	3 🗆 Pro	obably 4 🗌 Unknown		
COL	aw rec as bee	Completed by					_	-		ppsy	prior to c	opsy findings available ompletion of cause of		
Re	: The I								1 🗌 Yes	ormed? 2 No	death?	2 🗌 No		
ital	sician certifi irector	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	0 TJ	ED/Outpotion	26. Pl	or:	Check only one)	idones 6 🗆 O	thor/Caosi	5.1		
of \	g Phy er this seral d	te: To	27. Manner of Death	28a. Date of inju (Month, Day	у	28b. Time of injury		y at		how injury occi		19/		
on	eath. or: Aft	fical	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	tion	, real)			Yes 2 No						
Division of Vital Records,	or Att	Certificate:	4 Homicide determine				eet, factory, office			(Street and Nun wn, State)	nber or Run	al Route Number,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying P	hysician: To the best of	my knowle	edge, death	occured at the time	e, date and place	ce, and due to the c	ause(s) and ma	nner as sta	ted.		
	the Ho nin 24 the Fu	Medical	only one) 3 Certifying N	uminer: On the basis of e urse Practioner: To the	camination best of my	and/or inves knowledge,	death occurred at th	e time, date and	red at the time, date d place, and due to t	and place, and he cause(s) and	manner as	ause(s) and manner stated. stated.		
29b. Signature and title of certifier 29c. License number 20c. License number 20c. Augustus and title of certifier 20c. Augustus and title of certifier 20c. License number									29d. Date sign	ned (Month,	, Day, Year)			
			30. Name and address of person wh	P	eath (Item	23a) (Type. I	Print)	201		10/5	1			
			RANI S. KARI	PINENI	202	W.M.	APLERI), div	THICUI	4,19) 2	1090		
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 4 201	22. Registra	r's Sign	ure far	Kal		THICUI					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene 31488 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29,2011 Physician/ 6:32 P M Katherine Green September Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death 210 West Road Essex 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Days 216-28-4837 **Director** 1 □ M 2**X** F 78 May 25,1933 West Virginia or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Baltimore Essex 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21221 USA 210 West Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. "natural", or à 1 Never Married 2 Married 1 Yes 2 XNo Specify. Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical Secretary 12 years marked other Be Important: If tem 27 is marked oft any injury or other traumatic event once. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mollie Mareno James R. Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Green son 210 West Road, Essex, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland 4,2011 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Signature of Funeral Ser Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown ę Month Dav Year the funeral director, page 2 should be detached by the 9 Unknown o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After (Month, Day, Year) 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a To the Funeral I Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely only one Certifying Nurse Preditioner To the best of my knowledge. Jest commit at the time, date and place, and due to the cause(s) and market as stated 29b. Signature and 2 29d. Date signed (Month, Day, Year) 30. Name and add ss of berson who completed cause of death (Item 23a) (Type, Print) 2300 DULANCY VALLEY RD TIMONIUM, MD 31. Date filed (Month, Day, Year) State Registrar

SEPTEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # State of Maryland / Department of Health and Mental Hygiene For State Registrar 31489 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept 29, 2011 Salvatore J. Guercio 9:12PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Parkville Baltimore 2821 Linwood Avenue Year) 1939 Social Security Number 8. Date of Birth (Month, Day, Year)
Oct.14, 1936 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 213-36-8354 71 1 🛮 M 2 🗆 F **Director** Maryland Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hyglene. and tifene 23a or 28a-f sho and tifene 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville MD Baltimore 1 ☐ Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2821 Linwood Avenue 21234 United States 12. Was Decedent Ever in U.S. Armed Forces?

★ X Yes 2 □ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXio Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lucent Technology Service Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Concetta M. Cefalu Peter Guercio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2821 Linwood Ave, Parkville, MD 21234 Barbara Guercio-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 10 - 4 - 11Parkville, Maryland Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Opproximate Interval Between Onset and Death Approximate Immediate Cause (Final HERATOCELLULAR Physician/ disease or condition resulting in death) MONTHS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ HEPATTC CIRRHOSIS 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed DIMBETES 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State within 24 hours a

To the Funeral C

completely filled To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D40480 SEPTEMBER 30 2011 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7602 BELAIR ROMO FEDENANDE 21236

State Registrar 31. Date filed (Month, Day, Year) OCT 0 4 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav PM Physician/ ober Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Ballinnere 8. Date of Birth Month, Day, Yea 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min 217-56-648 1 2 M 2 □ F Months Days Hours extand Director 2 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 0 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces Completed by 1 Never Married 2 Married 1 Yes 2 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Armeo WH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ire Rd. atricia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Doyation 5 ☐ Other (Specify) . Park re of Funeral Service Lice 22. Name and Address of Facility 3405 Fa 21. Si Tr 21224 mod. aci 23a. Part 1. Enter the disease, or complications that caused shock, or head failure. List only one cause on each line. Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last signed by the attending physician and dbe detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Vital Records, 1 🗌 Yes Completed plnous Robent 24a. Was an 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsv death? 2 11/10 1 Tyes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: မ 1 🗌 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Division of 28c. Injury at work?
1 ☐ Yes Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural injury 5 \square Pending 2 🗌 No Accident Investigation completed filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined Medical 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 24070

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

VERMA

SANGITA

31. Date filed (Month

For State Registrat State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Name (First, Middle, Last, 2. Date of Death 3. Time of Death VOEmoc Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Johns HOPKINS Himore 5. Social Security Number Year If Under 24 Hrs. Age (In yrs, last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) India 1 M 2 X F Month, Day, Year)
December 23,1929 Months Days Hours Min. Director 81 236-86-0379 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director notified a 1 Yes 2 X No Maryland Howard Ellicott City 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 12685 Golden Oak Drive 21042 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or other traumatic event, the Medical Examiner Black, White, etc. 0 ð 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Asian Indian "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ should be Mohanlal Mehta Dhanalakshmi Mehta 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it. Page 1 and 2 s rtment of Health 27 Chandravadan Gandhi <u>2685 Golden Oak Drive, Ellicott City, MD 21042</u> permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 3 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State September 30, West Arundel 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Odenton, Maryland Crematory 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 . Signature of Funeral Service License M01386 Part 1. Let the disease, or comilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in failure. List only one cause on each line. 23a. Part 1 e cause on Interval Between Immediate Cause (Final Onset and Death Physician/ Aspiration disease or condition Medical resulting in death) Examiner Metastatic cancer Sequentially list conditions, Examine Due to (or as a consequence of) in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown 1 Tyes should been 24b. Were autopsy findings available 24a, Was an has prior to completion of cause of death? autopsy performed? Yes 2 No To the Hospital or Attending Physician: The this certificate 2 🗌 No 1 Tes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year, 90 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St. Baltimore MO 21287 Pant Nath Hom 31. Date filed (Month, Day, Year, ₽egistrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O. |

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sept 2Ŏ<u>1</u>1 Marrie Gause Medical 3:30 A_{\bullet}^{M} 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Randallstown Baltimore Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 1 - M 2X F Months Hours 08-29-25 250-38-9601 86 Director SC Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Funeral Director 10d. Inside City Limits MD BALTIMORE Randallstown 1 X Yes 2 ☐ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? items 23a 9109 Liberty Road 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give ò Black, White, etc. African 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 Nidowed 4 ☐ Divorced Specify: American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. Elementary/Seconday (0-12) College (1-4 or 5+) 7th Grade Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sylvester Wilson Helen Livingston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Johnson-Daughter 3112 Windsor Avenue Baltimore, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place)
Garrison Forest 10-07-11 4 Donation 5 Other (Specify) Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wille Fineral Home P.A. 638 N. Gilmor Street, Baltimore, MD 21217 rotorum 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Dementia Advanced Medical Due to (or as a consequence of): Examiner cirches vas cular Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Diskito (or as a consequence of, Coronary artery
Due to (or as a consequence of) that initiated events resulting in death) Last Be Completed by Physician/Medical Box 68760 as IF FEMALE use If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year been signed by the should be detached P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hyperten sion Division of Vital Records, 1 Tes 2 No 3 Probably 4 X Unknown Anemia of Chronic disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🕷 No 24a. Was an r this certificate has ral director, page 2: autopsy performed? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page Yes 2 X N 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) ပ 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/29/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9109 Liberty Farah Bozon Rd. Randallstown 21133 31. Date filed (Month, Day, Year) 32. Registrar's Sig

Registrar

4 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SEORGE 16:22 GREENWALT 2011 OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. JULY 18, 1959 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F MARYLAND 215-78-3963 52 Director Usual Residence of Decedent death with the Maryland or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes X No Director MD BALTIMORE DUNDALK 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country? 6 must be 2**3**a 952 DALTON AVENUE 21224 Funeral U.S.A. Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: þ WHITE 3 Widowed 4 X Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4 or 5+) than and Mental Hygiene. LABORER CONSTRUCTION 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MELVIN W. GREENWALT LOWERY PATRICIA Α. ဂ္ traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 PATRICIA GREENWALT/MOTHER 11105 SENEDO ROAD, MT. JACKSON, VA 22842 other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of I important: If ite any injury or of once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BAYVIEW CREMATORY 10/5/11 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final Physician ESPIRATORY FAILURE DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 5 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events NEUMONIA Examiner The law requires that the death certificate be executed nding physician and use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) d by the al 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed h 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ METASTATIC LUNG CANCER 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate has 2 VNo 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 -Natural s after death.

I Director: Afted in by the fu 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 🗌 Homicide or A after City or Town, State) Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Claria Cettomau, MD KES-000 OCTOBER 1, ZUI 1

Registrar

DHMH 17 Rev 1/2001

11595

State

32. Registrar's Sgnature

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EANNA CETTOMAL, MD

0 4 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND ITEM#6perFH, G920, 10/18/2011, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 1494 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 Day 28 Year Joseph Daniel Gillts :06 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1636 Ingleside Ave. Gwynn Oak Baltimore Co 5. Social Security Number Sex 1 A M 2 1 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 011/21/1950 216-54-0521 Maryland **Director** 61 Yrs Usual Residence of Decedent 28a-f shov 10b. County 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Gwynn Oak Baltimore Co. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1636 Ingleside Ave. 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2x Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black "natural" 3 Divorced 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Man 1 0th Grade College (1-4 or 5+) Baltimore Co. School Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick Gillis Geneva Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Gillis(wife) 1636 Ingleside Ave., Gwynn Oak, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Arbutus Cem. 10/08/11 |Baltimore, MD Josephdom Frewown Jr. 2140 N. Fulton Ave., of Funeral Service Licensee Signatur Funeral Home PA Baltimore, MD 21217 2140 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) eumonio days Medical Due to (or as a consequence of) **Examiner** Sta ta ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy perform death? certificate 2 No 1 Yes Yes within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? (2 Hospital 2 X No pital:
1 M Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year)
28b. Time of
injury
28c. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of dertifier and address of erson who completed cause of death (Item 23a) (Type, Print) 10 NOIN 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 11:40A M SEPTEMBER 28, 201 Alan Hoover Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
BALTIMORE 4b. City, Town, or Location of Death **Examiner** SAINT JOSEPH MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 | F (Month, Day, Year) 04/09/1943 Maryland Director 213-42-3091 68 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Examiner must be notified at Director 1 🛚 Yes 2 🗌 No MD Baltimore Towson 23a or 2 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 305 E. Joppa Road. 21286 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 X Never Married 2 Married ò þ 2 X No Maryland 21215-0036 72 hours after 1 ☐ Yes 2 K No Specify: If Yes, Give and Mental Hygiene. is marked other than "natural", Specify. 3 Widowed 4 Divorced Completed White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supervisor Industrial Be Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jack E. Hoover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3663 Seaford Court, Pasadena, MD 21122 William Hawley / Friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☑ Donation 5 ☐ Other (Specify) 10/03/2011 Anatomy Gifts Registry Hanover, Maryland 21. Signature of Juneral Service Linensee 22. Name and Address of Facility any in Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physicanni ANOXIC ENCEPHALOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CARDIO RESPIRATORY ARREST Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of MYOCARDIAL INFARCTION and I-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last ng physician ar as the burial-t Physician/Medical PNEUMONIA Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, VENTRICULAR ARRHYTHMIA 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No CARDIOMYOPATHY Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🖂 No 1 🗌 Yes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phwithin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D31826 9-28-11 rist ricum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD LINTHICUM M.D. 7601 OSLER DRIVE TOWSON, MD 21204 31. Date filed (Month, Day, Year) **0CT 0 4 2011** State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 3 | 496 Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bett Month Mar 6 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death Howard Howard County General Hospital Columbia 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Days Hours Min (Month, Day, Months Yrs 1933 Director 215-26-5894 Maryland Mar Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Columbia Howard 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21045 6569 Fruitgift Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: White 3 X Widowed 4 Divorced and Mental Hygiene.

Is marked other than "nature raumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturer 8 Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lena M. Jackson Edgar M. Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6569 Fruitgift Place Columbia, MD 21045 Donna K. Milbourne/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Final Journey Crematory 10/03/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Going Homes Cremation Service P.O. Box 784 MD 21029 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner EUMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (q 124 hours after death. e Funeral Director After this certificate has been signed by the attending physician and Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed 10 Ca that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 10 Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 1 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital Other: ျ 1 🗌 Yes 2 🗆 💢 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 only one 29b. Signature and title of certifie 00565 201 eath (Item 23a) (Type, Print) 30. Name and address of person who completed cause of HOWARD COUNTY GENL HOSPITA 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 31497 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OS MARGARET HAYES 7-15AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manorcare Health Services-Rossville Rossville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct.3,19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Country)
Maryland **Director** 218-22-5176 Oct. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must have also any injury or other traumatic event, the Medical Examinar must have also any injury or other traumatic event, the Medical Examinar must have also any injury or other traumatic event. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1320 Sulphur Spring Road 21227 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1st grade n/a House Keeper Funeral Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Leonard Maude Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph F. Ambrose, Sr./nephew 5515 Osage Avenue Arbutus, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔽 Burial 2 🗌 Cremation 3 🗌 Removal from State Elkridge, MD 4 Donation 5 Other (Specify) Meadowridge Mem. Park Oct.1,2011 Signature of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ mony disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnance in the past 12 months? Day Pregnant at time of death Other (specify) signed by the a d be detached f 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 🔀 Unknown Completed certificate has been si irector, page 2 should l 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🗹 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 No. 2 □ No. မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; injury 1 Natural 5 Pending 2 Accident 9-02 AM 1 Yes 2 No It tell from chair Investigation 09/21/2011 6 Could not be Suicide
Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined PLIDGE RID BRITAMORE MIDZIESS Nursing home 6600 Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 28/11 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOAIB A. HASHMIMD 821 N. EUTAW St Inte 308 31. Date filed (Month, Đay, Year) -State Registrar

DHMH 17 Rev 7/2009

rds. P.O. Box 68760 Go Batimore. Maryland 21215-0036

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			State of Maryland / Department of Health and Mental Hygiene												3149	0	
	_		Registrar 1. Decedent's Name	e (First, Middle, La	ast)		Certificate of Death							Reg. N& U			_
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	Examin	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death City Coulthouse City									tu	4c. County of Death N/A				
	Funeral Director		5. Social Security N	umber 6.	Sex	7. Age (In yrs.	last birthday)	If Unc	er 1 Year Days	If Under	24 Hrs. Min.	8. Date of Bit (Month, De				place (State or Fore	eign
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lanylano	ka-fsho ified at	ector	10a. State MD	10b. County N/A		10c. City, Town or Location Baltimore									0d. Inside City Lim 1 X Yes 2		
with the M	23a or 28 ıst be not	Funeral Director	10e. Street and Nun				10f. Zip Code 21209								hat Cour	ntry?	
21215-0036 within 72 hours after death	or heatin and wentan tryglene. The man and with an "patental", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be Completed by Fun	11. Marital Status 1 ☐ Never Marr 3 X Widowed	ed 2 Married	12. Was Decer Armed For 1 Yes If Yes, Give Year or Da	2 X No	cify Yes or No- Rican, etc.)	-	- Americ k, White,								
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212 within	glene. erthal the N	Con	Elementary/Seco	endary (0-12)	College (1- N/a	4 or 5+)			epin	ıg			Lev	inda	ndale N/H		
Maryland 2 should be filed	nental Hy arked oth itic event	To Be	17. Father's Name (I	First, Middle, Last)	unknw	n				18. Mothe	, Maiden	den Surname) unknwn					
Mary 2 should	in and in		19a. Informant's Name/Relationship (Type, Print) Anthony Harris-StepSon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1700 Meridene Drive Apt. 214 Balto, MI													39	
ore, land	Department of hearth a lmportant: If item 27 is any injury or other trainonce,		20a. Method of Disp	osition	_	20b. I	Place of Disponentery, crei	osition (N	ame of			Date	T			own, State	
Baltimore,	tant: If		4 Donation	Cremation 3 5 Other (Spec	ify)	Otate	. Carı	mel	Cemt	1		/2011					
Bal	Departmen Important any injury once.		21. Signature of Fur	neral Service Licer	isee Da		A.	2. Name a	and Addres	ss of Facility	Ma , M	rch F, D 2120	/H 1 02	.101	Ε.	North	
	sician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a.												Approximate Interval Between Onset and Death		
	ledical aminer		resulting in death)														
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Box	he attending ied for use as	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	☐ Ectopic ☐ Other (Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Year							
IS, P.O.	signed by tild be detack	≨	Part II. Other signif	cant conditions	contributing to de	eath but not res	sulting in the u	underlying	g cause giv	ren in Part I.						ne cause of death?	
of Vital Records, ng Physician: The law requires	ate has been sig page 2 should k	Completed											psy ormed?	pi	rior to co eath?	psy findings availal mpletion of cause 2 No	ble of
tal F	certificate rector, pag	BeC	25. Was case referre	d to medical					26. Pla	ace of Deat	h (Check	1 \(\superset \text{Yes}\)	2 [KL Ni	0 1	L res	2 L 1 NO	
of Vi	this al di	유	1 Yes 2 2		Hospital: 1 1 1 28a. Date of	npatient 2 🛚	ER/Outpatie		Othe 28c. Injury	4 ∟ Nu	1	me 5 Resi)	
sion c ttending death.	or: After he funer	licate	1 Natural 2 Accident	5 Pending Investigation	(Monti	h, Day, Year)	injury	М	work'		- 1	zou. Describe	now injui	y occurre	u .		
is o ≥	Direc in by	al Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									28f. Location (City or To			or Rurai	Route Number,	
Div	e Funeral l	Medical	(Check 2	Certifying Phy Medical Exam	niner: On the basi	s of examinatio	n and/or inves	tigation, in	n my opinio	n, death occ	curred at	the time, date:	and place	, and due	to the ca	use(s) and manner s	stated.
29b. Signature and title of certifier 29c. License number										29d. Da	te signed	(Month,	Day, Year)				
	2		30. Name and addre	es of norson who	completed asset	of death (the	M 1)	Print\		314				7(3			
	2		Stock Name and address of the Stock Name and Address of the Stock	A-HA	SHMI !	ND, 8	21 W	, E		2 W	4	into 30	2 3	ALT	lmo	RE MD	길길
F	Stat Registra	=		CT 0 4 20		gietrar's Signa	. ba	Med									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 28, 2011 Sally Sisk Heckendorn Medical 4:35 a^{M} 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Oct. 20, 1930 9. Birthplace (State or Foreign 1 M 2 K F Days Hours Min. 577-40-3205 Country) Director 80 Yrs. DC Usual Residence of Decedent 28a-f show 10a. State the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George XX Yes 2 No Laurel 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7601 Erica Lane 20707 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ō Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrator Education Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Filmportant: If item 27 is marked or any injury or other traumatic was 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ John Lewis Sisk Sallie Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Rodriquez/ Daughter 515 Greaton Ave., Davie, FL 33325 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) November 4 Donation 5 Other (Specify) Arlington Nat.Cem. 2011 Arlington, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01053 313 Talbott Ave., Laurel, MD 20707 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physici ... disease or condition resulting in death) HEALTH CARE - ACQUIRES SAUS Medical Examiner PERITONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying WEEKS Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be execute ULCER WEEKS ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC KIONEY DISEASE Completed 2 No 3 Probably 4 Unknown CARBIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? certificate 1 🗌 Yes **Director:** After this certific in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HUSPICE မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending work? Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in my appliant death occurred. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) SEPTEMBER 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

COLUMBIA, MD 21044

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2011 32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 31500 State of Maryland / Department of Health and Mental Hygien & U Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1653 Alice Elizabeth Martin Hand September 26, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 819 Dorsey Avenue Baltimore Essex 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕱 F Months Hours Director 218-72-0245 Maryland 39 Apr 22, 1972 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Extension must be matified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 819 Dorsey Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Patrick Hoyt Hand Judith Ann Martin ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Claire Wood/sister CMR415 Box 4022, APO, AE 09114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Final Journey Crematory 10/04/11 Woodbine, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligenses Going Home Cremation Service P.O. Box 784 WEM01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the dischee, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failine. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tran that the death certificate be exec Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Year Month 5 ☐ Other (specify) ed by the 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 09/26/2011 1 ☐ Yes 2 No BY 1653P 2 Accident Suicide Hangin 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8/930 \$ 500 AU Lowe 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

State Registrar 31. Date filed (

onth, Day, Year)

DHMH 17 Rev 1/2001

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